Assessing the Efficacy of Treatment Modalities in the Context of Adult Drug Courts

Final Report

April 18, 2003

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This project was funded under grant #2000-DC-VX-008 by the US Department of Justice, Office of Justice Programs, National Institute of Justice. Points of view expressed are those of the authors and do not represent the official position of the funding agency.

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Abstract

By

Donald F. Anspach and Andrew S. Ferguson

Drug treatment courts have been heralded as one of the major justice reforms of the 20th century. They are intended to reduce the recidivism of drug involved offenders by changing their drug using habits. The purpose of this study was to examine the efficacy of treatment modalities in the adult drug court setting. The research examined treatment services and organizations involved in drug court operations across four jurisdictions: Bakersfield, California; Creek County Oklahoma; Jackson County, Missouri; and St. Mary Parish, Louisiana. The evaluation consists of an analysis of 2357 drug court participants as well as an exploratory study of the nature and quality of treatment inside the drug court. Using a combination of surveys, interviews, and observations of treatment sessions, this study examined the type of services delivered to the drug court offenders. These combined methods were used to begin exploring issues related to the integration of treatment within the drug court setting and the types of services provided to the offender.

Each of the four drug court programs are diverse with respect to size, participant eligibility, program protocols, drug testing and treatment attendance requirements. There is also substantial diversity in the nature and types of treatment services provided and the content of those treatment services. Overall results of the observational study and survey of treatment staff reveal that counselors' philosophies of addiction and effective interventions for treatment of substance abuse is broad and eclectic suggesting lack of a coherent, consistent approach in the manner in which counselors not only think about but also how they respond to clients' drug abuse.

Previous research on the "black box" of the drug court intervention is limited. The research literature confirms the existence of wide variations in the delivery of key components of drug courts – treatment, testing and sanctions, but little information on how the delivery of these components are related to client outcomes. This research examined how variations in completion rates and recidivism are related to differences in program compliance requirements such as drug use and treatment attendance. While compliance with program requirements are the most important factors associated with graduation, some participant characteristics also play a significant role. Findings also indicate that program completion is the most important predictor of post-program recidivism. Offenders who "successfully" complete the drug court program through graduation are at least three times <u>less</u> likely to be rearrested. At one drug court it was found that program completion was not a significant predictor of recidivism. Rather, the low overall rate of recidivism found there was related to the high overall rate of treatment attendance regardless of whether participants graduated from the program or not.

Assessing the Efficacy of Substance Abuse Treatment in the Context of Adult Drug Courts

Preface

This report was prepared for the United States Department of Justice, National Institute of Justice, under the supervision of Dr. Janice Munsterman. Dr. Donald F. Anspach of the University of Southern Maine was the principal investigator. Andrew S. Ferguson of the University of Southern Maine was the research analyst. Through a sub-contract with the Bureau of Governmental Research at University of Maryland, Dr. Faye Taxman and Dr. Jeff Bouffard conducted observations of treatment sessions and conducted surveys and interviews with treatment personnel at each of the four research sites. Donald Anspach and Andrew Ferguson conducted interviews with court personnel and collected participant level data at each site.

The report is truly the result of a collaborative effort. Without the dedication of the entire research team this research would not have been possible. The entire research team reviewed and commented on various chapters of the report. The division of labor is as follows: Dr. Faye Taxman was the lead author of the first chapter of the report and Dr. Jeffrey Bouffard was the secondary author. Andrew Ferguson and Jeffrey Bouffard were the lead authors of Chapter 2. Donald Anspach was the lead author of Chapters 3, 8, and 9 with Andrew S. Ferguson as the secondary author. Faye Taxman, Donald Anspach and Jeffrey Bouffard were the authors of Chapter 7. Chapter 4 was written by Jeffrey Bouffard, Donald Anspach and Andrew Ferguson. Jeff Bouffard was the lead author of Chapters 5 and 6 with Faye Taxman as the secondary author. Chapter 10 was written by Donald Anspach and Andrew Ferguson. Faye Taxman was the lead author of the Executive Summary with Jeff Bouffard, Donald Anspach, and Andrew Ferguson as secondary authors.

April 18, 2003

Acknowledgements

The University of Southern Maine and the University of Maryland would like to give a special thanks to everyone for whom otherwise, this work would not have been possible. Special thanks, undoubtedly, are deserved to every member of the four Drug Court teams involved in this study. In particular we would like to thank:

St. Mary Parish
Staci Bertagna
Carolyn Dishman
Billi Driskell
Hon. William Hunter
Keena Lanceslin
Lars Levy
Brett Matherne
Bernadette Melancon
Ralph Melancon
Lewis Pitman
Peter Raymond
Walter J. Senette

Creek County
Angela Cooper
Dana Davidson
Andrea Dawkins
Stephen Foster
Larry Fugate
Maureen Guerrero
Dr. Paula Inbody
Mike Loeffler
Jessica Rainey
Hon. Richard Woolery

Bakersfield
Lily Alvarez
Carol Avry
Allen Belloumini
Hon. Frank Hoover
Michael Johnson
Hon. Sharon Mettler
Marti Rodriguez
Bonnie Sanders
Stephen Tauser
Steve Wilhelmsen

Jackson County
Robert Baird
Vicky Boyd
Jeanna Brennan
Monica Cervantes
Judy Chase
Hon. Greg Gillis
Jim Nunnelly
Denise St. Omer
Joseph Reed

University of Maryland
Carol Gibbs
Rebecca Silverman
Lee Ann Slocum
Julie Marshall

Correctional Counseling, Inc.
Dr. Kenneth Robinson

Glacier Consulting, Inc.
Dr. Robert Kirchner

University of Southern Maine
Michelle Baker
Dr. Vincent Collom
Jody Giambattista
Laura Phillips
Martha Hamlin

Federal Bureau of Investigation
David Lavezza

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Executive Summary

The United States has the western world's most serious (per capita) drug problem, whether expressed in terms of addiction to illicit drugs, drug related crime, or intravenous drug use-related HIV (Marlowe, 2002). For nearly thirty years, the criminal justice and drug treatment systems have struggled with a structural process to provide timely access to drug treatment services for offenders (Belenko, 2000; Taxman, 1998). In response to the need to provide drug treatment services, jurisdictions have created a number of innovations including case management services to advocate for services for offenders (e.g. Treatment Alternatives to Street Crime), specialized in-prison or in-jail treatment programs, specialized probation or day reporting programs, diversion programs, and drug courts. Studies on the efficacy of such innovations have mixed results, with some approaches reporting reductions in recidivism and others not; more often the research is of insufficient quantity or quality to convincingly determine the efficacy of the innovations (Sherman, et al, 1997; Anglin, et al, 1996; MacKenzie, 2000; Taxman, 1999).

One theme echoed in many of the studies is that the overall operation of treatment services for offenders has not been affected by the innovations, and treatment services for offenders continue to be inadequate to meet the needs of offenders (Duffee and Carlson, 1996; Lamb, et al, 1998). Overall, few meaningful changes at the systemic level have been realized as a result of these innovations in treatment delivery format. However, new demonstrations are evolving as to how to integrate treatment in the criminal justice system (Harrell, et al., 2002). Even more importantly these treatment programs continually struggle with ensuring the stability of treatment services as resources increase and decrease over time. Estimates are that of the 45 percent of offenders in need of drug treatment services (Taylor, Fitzgerald, Hunt, Reardon, & Bernstein, 2001) only a mere token of offenders receive any services. Additionally, few services are adequately matched to the treatment needs of the offender (Belenko, 2000; Farabee, et al, 1999; Taxman, 1998). Despite the attempts of the innovations described above, many scholars continue to suggest that the services are not integrated into the operating philosophy of criminal justice programs (Taxman and Bouffard, 2002b; 2000; Harrell, et al., 2002) and that there is a limited linkage between the treatment and criminal justice system.

The most recent example of innovations in substance abuse service delivery systems for offenders, drug treatment courts, were developed in 1989 in Miami, Florida as a means to overcome the haphazard provision of treatment services, and to integrate treatment into the normal, daily operations of the court and supervision systems. The court was viewed as the vehicle to bring the conflicting models of punishment and rehabilitation into a setting where the two philosophies could be integrated, instead of relying upon disparate programmatic components of treatment, drug testing, supervision/oversight, and compliance management (Taxman and Bouffard, 2002b; Goldkamp, White & Robinson, 2001). One of the most unique, specialized features of the drug court is the use of the presiding judge to oversee the progress of the addicted offender. The judiciary provides a routine basis to ensure compliance with both treatment and punishment conditions. In many ways, the concept of the drug treatment court reshapes criminal justice policy by forging the interdisciplinary team to address the addiction and criminal behavior of

offenders through integrated programming and through the altered role of the judiciary as a critical component of the program. As such, drug courts have been hailed as one of the major justice reforms of the latter part of the 20th century in the United States (Goldkamp, White, & Robinson, 2001).

Drug courts provide a programmatic process to address addiction as a chronic behavior with relapsing occurrences. The traditional justice system has struggled with responding to reoccurring *behavioral* conditions due to the tendency to be incident-driven and use the potential for incarceration as a response. Under the traditional system, little tolerance exists for the reoccurring nature of addicted behavior, and the criminal justice system constantly struggles with providing appropriate and proportionate responses for non-compliant behavior of addicts, such as their continued drug use. Under the drug court model, frequent status hearings provide positive reinforcement for the struggling addict and provide a means to respond to potential relapsing incidents. The drug court process recognizes the relapsing nature of addiction and provides the flexibility to respond accordingly. Therein lies the major difference between the drug court and the traditional treatment process for offenders—the integration of treatment goals within the fabric of the drug court process.

The drug court concept provides the opportunity to explore how treatment is integrated into the drug court setting. Few studies have examined this issue with a rigorous exploration of the organizational and structural issues regarding the use of treatment services and the subsequent impact of treatment delivery on client outcomes. Some critical questions need to be addressed regarding how treatment is utilized within the context of the drug court. In other words, how are drug treatment services provided within the framework of the drug court? What policies and procedures drive the drug court in recognition of the importance of treatment? The available literature on drug treatment courts does not address these questions, particularly the issues related to how treatment services are offered to offenders. Nor does it address the supporting policies and practices of the Drug Treatment Court that reinforce the goal of providing drug treatment: *to reduce the recidivism of drug involved offenders by changing their drug using habits*. The issues related to drug treatment are not well understood and the following focuses on such issues.

Drug Treatment Courts: The State of Knowledge

In the last decade while drug court programs thrived and grew to a nationwide phenomenon with over 700 courts (Cooper, 2001), studies of drug courts did not occur at the same pace. As noted in three reviews of drug courts studies, few studies use rigorous designs, which limit the conclusions that can be drawn about the efficacy of drug courts, compared to other innovations or traditional processes (Belenko, 1998; 1999; 2001). Some studies report findings that support the goals of reductions in judicial dockets, caseloads, jail bed days, police overtime, and system costs, although many of these studies do not have adequate comparison groups to substantiate the findings. At the offender level, within-program reductions in drug use and rearrest are generally reported, but again the nature of the studies limits the generalizability of the findings. The poor methodology used in many of these studies undermines the confidence that can be given to these apparently

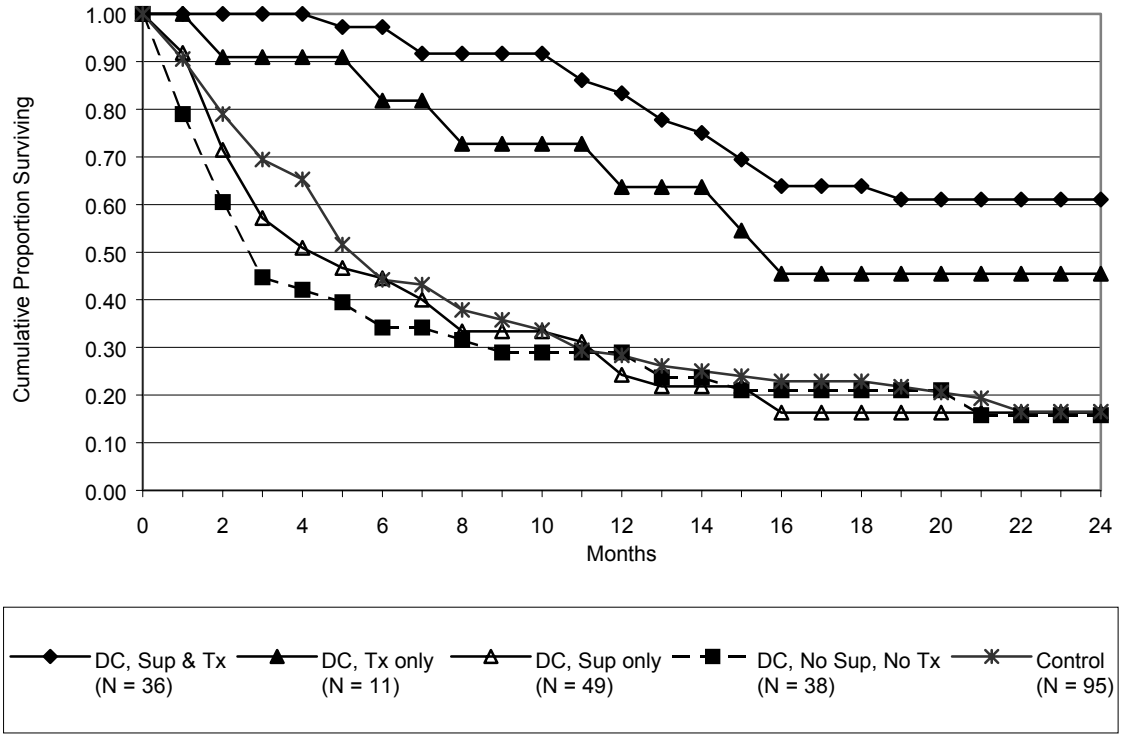
positive findings. Overall, the tendency in this literature has been to find that program graduates do better than non-graduates but scholars note that the lack of comparison groups limits an understanding even on this issue. According to Goldkamp, White & Robinson,

> "The findings appear to show a dramatic and consistent drug court crime reduction effect, with drug court graduates generally showing substantially lower rearrest rates…from entry than nongraduates. As popular as these kinds of analyses may be among advocates seeking to declare the efficacy of drug courts, they are biased in the direction of showing positive results, and as such, are highly misleading. Basically, the much-heralded findings show that the successes succeed and the failures fail. (2001:32)

In a comprehensive review of drug court research, Belenko notes that the findings tend to support four major conclusions about drug courts practice in comparison to general trends from other studies of correctional and/or drug treatment programs. First, the drug court appears to serve offenders with more serious criminal histories or originating charges than other community based interventions. Second, drug use among drug court participants is lower than drug use in other community programs. Third, graduation rates from drug courts tend to be higher than from other community outpatient drug treatment programs for offenders. Finally, during-program rearrest rates tend to be lower than other community programming based on the available literature. In comparison to the general trends, scholars tend to find that drug courts are promising innovations to improve offender behavior (Sherman, et al, 1997; Taxman, 1999; MacKenzie, 2000), however the research literature does not support firm conclusions about the effectiveness of the courts in all these domains. Similarly, the specific programmatic components that may produce these effects are not well documented as of yet.

The general findings tend to suggest that drug treatment courts provide an avenue for drug using offenders to participate in drug treatment, and as the model is developed and implemented it is likely that positive outcomes can be achieved for serious drug offenders as a result of their participation in drug court programs. Studies on the actual nature of services provided to offenders in drug treatment court are limited, but the available studies tend to illustrate that there is variation in the quantity of core drug court services provided to offenders. Five major studies have been conducted that employ sound research methods to explore the efficacy of drug courts, and to measure the services delivered to offenders (Harrell, Cavanaugh, and Roman, 1998; Deschenes, Turner, and Greenwood, 1995; Goldkamp, White, & Robinson 2001; Peters and Murrin, 1998; Gottfredson et al, 2002). In each of these studies, the percentage of drug court clients participating in treatment varied considerably from 35 to 80 percent. For offenders participating in drug treatment services, the length of time in treatment also varied from under 30 days to over two years. Deschenes, Turner & Greenwood (1995) found that 77 percent of the drug court clients in Maricopa County participated in drug treatment. The general finding appears to be that the longer the period of time in treatment, the greater the likelihood that the offender will graduate from drug court. And, more importantly, participation in drug treatment reduces the likelihood of rearrest. As shown in Figure 1, Gottfredson et al (2002) found that those offenders who had participated in treatment had the best survival rates compared to other drug court offenders that had supervision only, treatment only, or neither supervision nor treatment.

Figure 1: Survival Rate for Participants in Baltimore City's Drug Treatment Court By Type of Interventions Received



The impact of drug treatment participation among the drug court clients has not been thoroughly assessed in each of the studies. In the studies of the Baltimore City, Maryland court, the researchers found of the 48 percent of the drug court participants that participated in drug court, they spent an average of 47 percent of their drug court time in treatment. The rearrest rate for those assigned to drug treatment court is 66.2 percent over a 24-month post assignment as compared to 81.3 percent for the control group ($p<.05$). The average number of months to rearrest for the drug treatment court participant is 11 months as compared to 5 months for the control group. Goldkamp, White and Robinson (2001) found that the more treatment sessions participated in or the greater the percentage of time in treatment, the greater the reduction in rearrests during the one year from entry into a program.

Drug Treatment within the Drug Treatment Court Setting

While the limited studies on drug courts examine the service mix provided to offenders, it is not surprising that not all drug court clients receive drug treatment services. Few studies have actually examined the provision of such services and how these services are delivered. Existing research has found some conflicting evidence regarding the access and availability to drug treatment services for the drug court, suggesting the need for more research into the linkages between court and treatment (Taxman and Bouffard, 2002; Cooper, 2001).

In 1999, a survey of 212 drug treatment courts was conducted by the Treatment Accountability for Safer Communities Programs (TASC) with funding by the Office of Justice Programs and the Substance Abuse and Mental Health Administration. While the survey findings report that 'treatment services designed for and used by drug treatment courts comport with scientifically established principles of effective interventions" (2001:xii), Taxman and Bouffard in reviewing the survey results note that the "linkages to the treatment system appear for the most part to be compartmentalized." (2002b). The treatment services offered in the drug treatment court reflect the services available through the general substance abuse treatment community instead of being tailored to the needs of the drug-involved offenders. For example, 51 percent of the TASC survey respondents reported not having formal placement criteria for determining type of treatment services an offender was assigned to. This result suggests a treatment system that lacks a full array of available services. Despite this, nearly 61 percent of the courts reported having dedicated slots in specific residential, detoxification and methadone maintenance programs, however these dedicated slots represent a small percentage of the available service capacity. While the survey finds that courts reported access to a wide variety of services, this array is not typically available when needed.

Turner and her colleagues at RAND in a process study of 14 drug treatment courts note that "access to a continuum of alcohol and drug user treatment services and other related rehabilitative services was often difficult, reflecting financial issues, as well as difficulties with close coordination and information flow between treatment providers and other drug treatment court staff" (Turner, et al., 2002:1505). In this study, the researchers found that the linkages between the drug treatment court and drug treatment system tends to be characterized by informality where the court accesses available services but the drug treatment court and services are not well-integrated beyond these small-scale, often informal ties. While informality in linkages suggests that the services may not be responsive to offender needs, it does reflect the lack of policy and operational practice development needed to address structural issues regarding organizational barriers and other impediments to coordinated service delivery. The researchers note that referral and communication among the treatment providers and criminal justice system in these 14 drug treatment courts is still in its infancy, with the tendency for it to occur on an "as needed" basis. This characterization may be reflective of the early developmental stage of the drug court but it also suggests that drug courts have not necessarily built an interdisciplinary team case management approach as recommended by the National Association of Drug Court Professionals (1997). More importantly, the researchers found that there was still some tension between supervision and rehabilitation objectives in some drug treatment courts. These tensions generally resulted from the quality vs. quantity problems that affect drug courts where the push is to serve a larger number of offenders than is possible with available funds. Usually this results in short-changing some of the services that addict-offenders need to maintain their sobriety and crime-free lifestyle.

Taxman and Bouffard (2002), using the survey data from the TASC survey of 212 drug courts (see above), assessed some of the disconnects between the delivery of treatment services and drug court operations. Although the TASC study concluded that the drug courts engaged principles of best practices, a careful review of the results suggests

otherwise. In key areas, the drug court respondents highlighted the lack of policy and procedures that would support the drug court program's mission. For example, this sample of drug courts tended to target offender's eligible for drug court in reference only to their offense and criminal history, rather than in response to the type or severity of their substance abusing behavior. Half of the drug courts reported that they have non-clinical staff screen clients for drug treatment court eligibility, and nearly 60 percent of the drug treatment courts excluded offenders from participation who were "not motivated for treatment". Half of the drug courts reported not having any formal placement criteria to determine what type of treatment services the offender should receive, and case management services were reportedly not uniformly delivered using a treatment team format. In addition, the case management services that did exist were infrequently provided by the drug treatment court itself. According to these survey results, many of the courts have more than one agency conducting drug tests (e.g., treatment provider, probation, etc.) and often the results were not shared. While drug courts are designed to integrate services across systems, in order to create a boundaryless service delivery system, it appears from these survey results that few courts have developed such an approach. This raises many questions about the treatment services provided to offenders in the drug court setting and the impact of such services on outcomes.

To date, research on the "black box" of drug courts' actual intervention components is limited, particularly regarding the nature of drug treatment services provided within the context of drug courts. The findings from the few well-designed studies of drug courts (Gottfredson, Najaka, & Duran, 2002; Goldkamp, White, & Robinson, 2001) confirm that there is variation in the delivery of key functional components of drug courts—treatment, testing, and sanctions. These findings (as well as the stated rationale for the model itself) suggest that the key ingredient of the drug court approach is the delivery of drug treatment services. With little information on the organizational and structural components of the drug treatment services offered in the drug court setting and their impact on client outcomes an understanding of the drug court model is limited. To address these issues, this study was designed to examine the delivery of treatment services in four drug court sites. Specifically the study involves a retrospective analysis of the impact of functional drug court components on offender outcomes, both during program participation and during a one-year post program period. This study explores some of the issues related to the delivery of drug treatment within a drug court setting and then lays a foundation for future work in this area.

Methodology

This study of drug treatment delivery in drug courts uses a combination of qualitative methodologies and quantitative analyses of information collected from four relatively long-standing drug courts. Fieldwork was conducted from February 2001 to May 2002. On-site interviews were conducted with key stakeholders from all dimensions of the drug court (e.g., judges, probation officers, defense attorneys, prosecutors). Interviews were also conducted with treatment administrators and providers. Surveys were done with 52 counseling staff employed in the treatment agencies utilized by these four courts and a total 124 treatment sessions were also observed using a structured tool designed to measure

the nature and quantity of various clinical components of substance abuse treatment. A retrospective analysis of officially recorded information on 2,357 drug court participants also was conducted to explore how treatment participation is related to program completion rates, in-program and post program recidivism. The study methodology is designed to examine the delivery of drug treatment in the drug court setting and begin to explore the impact of this treatment across several client outcomes.

Sites

The sample of drug courts examined in this evaluation includes two located in relatively rural areas and two located in more urban settings. All four-drug court sites were chosen because their programs had been in operation long enough to have institutionalized their procedures. In fact each of the courts was designated as a "Mentor Court" by the National Association of Drug Court Professionals. Bakersfield is a relatively large, long-running court in a medium-sized California city, which utilized existing drug treatment providers within the local community. St Mary Parish is a rural court operating in Franklin, Louisiana, with a dedicated treatment provider that is part of the local county government. Creek County is also a small, rural court operating in Oklahoma, which at the time of the evaluation was using two private treatment providers within the community. Jackson County is a large court operating in a medium-sized Midwest City (Kansas City). This court, like St. Mary Parish made use of a dedicated treatment provider that was part of the court itself and was operated by local government.

Retrospective Analysis of Drug Court Participants

To understand the how drug court participation is related to program completion and recidivism, the study included a retrospective analysis of 2,357 offenders that were enrolled in drug court between January 1997 and December 2000. The sampling frame consists of all enrollees in drug court, regardless of their level of participation. Information about offender behavior and program participation was collected both during their program participation (i.e., drug testing, treatment, graduation, and rearrest). In addition, information on rearrest rates was gathered for a 12-month post-program period. As will be discussed below, none of the four drug courts had a management information system that maintained complete documentation of drug court participants' activities while in the program (e.g. drug tests, drug treatment sessions attended, sanctions levied, supervision meetings, etc.). Rather, various sources in each jurisdiction had to be tapped to gather the needed information, including the court, treatment providers, and supervision staff records. The data set that was compiled across the four sites include program information (e.g. drug court program start and end dates, number of treatment sessions attended, number of drug tests administered and number of positive tests), characteristics of participants (e.g. age, gender, ethnicity, marital status, substance use histories, drug of choice, etc.), type of graduation (e.g. successful, discharged, exceed program time frame), and rearrests during and after program participation. Rearrest data was gathered from the National Crime Information Center (NCIC) for all of the sites. This data includes information on arrests and full criminal history as reported to the national database. For the most part, the most complete information is maintained by the treatment providers (as compared to the courts)

and therefore the retrospective analysis tends to over-represent those drug court participants who actually attend their mandated drug treatment services. As will be discussed below, this limitation is significant because the most complete picture of drug treatment courts findings is from treatment providers, although other studies have found not all drug court offenders actually participate in drug treatment programs (Harrell, Cavanaugh, and Roman, 1998; Deschenes, Turner, and Greenwood, 1995; Goldkamp, White, & Robinson 2001; Peters and Murrin, 1998; Gottfredson, Najaka, & Duran, 2002

Procedures for the Qualitative Components of the Study

As part of this study, the researchers examined the treatment components of the drug court program to learn more about the actual nature of services provided. Data collection methods examined the counselors' philosophies of drug abuse causation and treatment, as well as the implementation of treatment services within the drug court context (using a structured, direct observation methodology). These data sources were then used to explore the orientation of counselors working with offenders in these four drug courts and to compare these orientations to the type of substance abuse treatment services delivered.

Observation of Treatment Services

Using weekly schedules provided by the treatment program administrators the research staff developed an observational schedule that maximized the number of meetings that could be observed during a four-day on-site visit. During each site visit trained observers were assigned to unobtrusively observe treatment meetings at the various programs in the jurisdiction. Counselors had previously informed their clients of the researchers' upcoming visit and no client in any program in any jurisdiction refused to participate in a meeting under observation. Observers recorded the amounts of time (in minutes) spent on each of several possible treatment topics and activities taking place in each meeting. Observers also recorded narrative information and completed several summary scales to further describe the exact nature of the services being offered.

Counselor Surveys

Treatment program administrators also provided a list of staff who were directly involved in the delivery of services to drug court offenders. The researchers provided each of these counselors with a survey packet during the site visit. Instructions in the packet directed the counselors to complete the survey and return it directly to the researchers via mail, in order to safeguard their responses. A total of 54 of the 92 counselors (58%) completed the survey. The counselor survey included information such as counselor's educational background, credentials and previous counseling experience, as well as typical counseling and related duties and caseload size. Counselors were asked to complete two questionnaires designed to uncover their philosophy of both drug abuse causation and the necessary components for effective treatment. The items comprising these two questionnaires largely mirror those developed by Taxman, et al (2001) including items representing conflict, labeling, social control, social learning, social disorganization and strain theories as well as some new items reflective of cognitive-behavioral (CBT)

approaches. For a discussion of the instrument refer to Taxman and Bouffard (2002a) and Taxman, Simpson, & Piquero (2002).

Table 1. Content of Counselor Philosophy Questionnaires

Theories of Substance Abuse…	Causation	Effective Treatment Components
Conflict	Powerlessness; Racism; Sexism.	Understanding societal problems of racism and sexism; addressing coping strategies and internal controls.
Labeling	Stigma; Formal and Informal Labeling; Deviance Amplification; Isolation. Addict as Master-status.	Avoiding internalization of negative labels and stigmatization; assuming mainstream role (e.g. parent, peer counselor, etc.).
Social Learning	Exposure to Drug Abuse; Role modeling criminal and non-criminal behavior; Exposure to drug use attitudes and behaviors. Rewards and Reinforcements.	Avoiding association with drug abuser; learning new behavioral responses to triggers/opportunities to drugs; developing prosocial and acceptable behaviors; teaching new lifestyle, peer associations and behavior.
Social Control	Social bonds of Attachment, Commitment, Involvement; Belief in Morality of Norms/Rules; Low Self-Concept; Containment.	Developing bonds to significant others, social institutions (e.g. school or work) or internal controls; creating a positive self image; discipline.
Strain	Failure to Achieve Positively Valued Goals; Removal of Positive Stimuli; Exposure to Noxious Stimuli; Distancing from Society.	Develop coping skills to deal with stressful situations; teaching anger and stress management.
Social Disorganization	Population Heterogeneity; Community Ecology; Community Control; Social Ills.	Developing sense of control by the individual and within the community; mobilizing community support issues; addressing housing issues; addressing work and social network issues.
Disease Model	Inherent predisposition to addiction, inability to moderate use.	Acceptance of "powerlessness", Reliance on a "Higher Power".
Anti-Social Values	Lack of prosocial commitments, beliefs.	Increase prosocial activities, recognize value of sobriety.
Cognitive-Behavioral	Lack of social, emotional, and coping skills.	Training in coping skills, life skills, cognitive monitoring and behavior management techniques.
Psychopathic Character	Lack of respect or empathy for others.	Perspective taking, empathy building.

Summary of Main Findings

Characteristics of the Drug Treatment Courts

Drug courts can be designed to fit into the local socio-political-legal environment of a community. Nationally, 90 percent of drug courts are post-plea courts where the offender agrees to the drug court as a condition of the sentence with the hopes of reduction in the arrest history with the possible expungement of the conviction upon successful completion of the program. The remaining 10 percent are pre-pleas where completion of the drug court generally results in an expungement of the record (Cooper, 2001). The actual process for establishing the target population (drug court program eligibility) and nature of the drug court's program components is a local decision usually based on the wishes of the relevant stakeholders and the availability of different services within the treatment community. Nationally, 8 percent are misdemeanor only courts, 40 percent are felony only courts, and the remaining 52 percent are misdemeanor or felony courts (Cooper, 2001). The target populations of the four study courts generally consisted of felony and misdemeanants

offenders, although the Bakersfield court did not allow felony offenders (as a concession to local political considerations).

The four drug courts included in this study adapted the general features of the drug court model to fit their particular needs. The courts for the most part were post-plea, except for Jackson County, Missouri. The courts used the existing judicial infrastructure to deliver services, holding status hearings weekly except in Creek County where the hearings occurred twice a month. All drug court clients were expected to attend the status hearings**.** None of the four courts had a structured set of sanction protocols (i.e., graduated sanctions menus) that are recommended for drug courts. The sanctions employed by this sample of courts did not operate within a framework of a written behavioral contract signed by the offender upon entry into the drug court. Except for the Bakersfield court, drug testing was administered by the treatment service agencies, with the treatment system sharing information on the testing results with court personnel. In Bakersfield, a private drug testing firm was contracted by the court to administer the randomized urinalyses. This agency then also provided reports to the court. True random testing occurred in Bakersfield where the offenders called in to determine the time and date of their drug test that week. Drug testing tended to be more frequent in the early phases of the drug court program and was generally less intense as clients progressed in the program.

Treatment services were delivered by either an array of local providers or by a dedicated treatment provider contracted by the court. Both models of service acquisition included some access to residential drug treatment services if needed (though Creek County specifically did not offer any residential services for drug court clients). Treatment services were offered during the full duration of the drug court period, ranging from 12 to 15 months. This is the amount recommended by the Office of Justice Programs given the addiction backgrounds of the offenders. Creek County did offer shorter duration of treatment programming based on the severity of the addiction of offenders with a range of 3 to12 months in duration.

Drug treatment providers tend to be community-based organizations that are either part of the public health system or private agencies. Many offer a variety of services including group counseling, relapse prevention (later phases), social and coping skills, and case management services. Support services are often offered through the local self-help community (AA, 12-steps programs) in each jurisdiction. In only one jurisdiction (Creek County), did the treatment providers incorporate and use a formalized treatment curriculum. The use of a formalized curriculum has been suggested to be an important component of effective treatment services (Lamb, et al, 1998). None of the treatment providers offer medical services on-site, rather these services were provided through referral to other local providers.

Table 2 Cross-Site Comparisons of Drug Court Structure, Operations and Phases

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Drug Court Structure	Post-plea, post adjudication	Post-plea, post adjudication	Post-plea, post adjudication	Pre-plea, pre-adjudication
Date of Inception	1997	1997	1993	1993
Program Length	15 months	3,6,9,12 months	12 months	12 months
Status Hearing				
Drug Court Status Hearings	Weekly	Bi-Weekly	Weekly	Weekly
Drug Testing				
Random Testing	Yes	No	Yes	Yes
Tested By	Treatment	Treatment	External	Treatment
Amount by Phase	2x week, 2 months 2x week, 4 months 1x week, 3 months Monthly, 6 months	2x week, 3 months 1x week, 3 months 1x biweekly, 3 months Random, 3 months	2x week, 2 months 1x week, 4 months 1x week, 3 months	2x week, 4 months 1x week, 4 months 1x week, 4 months
No. Drug Tests	66	42	64	64
Treatment				
No. of Providers	One Private	Two Private*/ County Heath	Multiple Contractors to County Health	County Health
Differentiated Program Levels or Tracks[1]	One	2 drug court tracks 4 treatment tracks	One	Six treatment tracks
Phase I	2 months	3 months	4 months	4 months
Phase II	4 months	3 months	4 months	4 months
Phase III	3 months	3 months	4 months	4 months
Phase IV	6 months	3 months	NA	NA
Closed Groups	No	No	No	No
Formalized Curriculum	No	Yes	Yes (some)	Yes
Individual Counseling in addition to group	No	Yes	Yes	Yes

Each court has a different process for determining who is eligible for participation in the drug court program with different actors responsible for making these decisions in each jurisdiction. In two sites the initial, legal review of a case (of current offense and criminal history) is performed by prosecutors (Creek County and Jackson County), while probation is responsible for this review in the other two sites (St. Mary Parish and Bakersfield). None of the sites used a standardized risk assessment tool to guide the legal screening process. The legal screening generally precedes the clinical assessment that is typically conducted by the treatment provider. This bifurcated decision-making process means that the severity of the substance abuse need is usually secondary to the participant's legal (offence and criminal history) eligibility, and that decisions regarding participation tend to not include the addiction issues.

[1] Does not include participants placed in residential treatment

Table 3: Decision Making Process for Eligibility for Drug Court

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Target Population	felony or misdemeanants	felony and misdemeanants	misdemeanant offenders	First time felony and misdemeanants.
Legal Screening	Probation from DA Office	District Attorney	Probation	District Attorney
Legal Screening Tool	Non-standardized	Non-standardized	Non-standardized	Non-standardized
Risk Screener	No	No	No	No
Clinical Screening & Assessment	Treatment Provider	Treatment Provider	County Dept. of Mental Health	Treatment Provider
Screening Instrument	ASI	SASSI, LPQ, Mortimer	Self-Developed Non-standardized	ASI
Clinical Assessment Instrument	ASI and Interview	Self-Developed Bio-Psychosocial and Interview	ASI and Interview	ASI and Interview
Mental Health Assessment	Treatment Provider	Referred	Treatment Provider	Treatment provider
Case management	Treatment Provider	Treatment Provider	County Dept. of Mental Health	District Attorney's Office
Treatment criteria used to exclude	Mental health, substance abuse severity	Substance Abuse Severity, mental health, motivation	Mental health, substance abuse severity	Mental Health and lack of motivation

Characteristics of the Participants in Drug Treatment Courts

The following table illustrates the type of offenders participating in the four drug courts. For the most part, offenders in these courts have had a significant criminal justice history with over 59 percent having two or more prior arrests. Many of the offenders have had arrests for personal and property offenses as well as drug offenses. The instant offense tends to be a drug crime, with a majority representing felony offenses. Drug use histories vary by jurisdiction but the drug court tends to include offenders that abuse crack/cocaine, amphetamines ("Meth") and marijuana. Information on the severity of substance use was either not available or maintained by the program sites. Prior substance abuse treatment experience varied by site with a range of 18 percent (Bakersfield) to 48 percent (St. Mary Parish) with an average of 28 percent.

Table 4: Characteristics of Offenders Participating in Drug Courts by Site

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Prior Criminal History					
Number of Prior Arrests					
None	10.9	34.9	8.6	22.1	17.9
One	23.2	20.8	14.7	28.5	23.1
Two or More	65.9	44.3	76.7	49.4	59.0
Mean number of Prior Arrests	3.6	1.9	6.7	2.2	3.7
Types of Prior Arrests					
Personal	13.0	7.6	12.7	9.3	10.8
Property	29.5	19.2	23.1	27.1	25.5
Motor Vehicle/DWI	5.2	28.7	3.2	2.4	4.7
Drug	38.8	37.7	50.7	54.7	50.6
Other	13.6	6.8	10.3	6.5	8.5
Drug Court Arrest					
Personal	6.4	2.1	8.9	2.3	4.7
Property	22.3	7.3	9.3	9.7	10.6
Motor Vehicle	0.5	1.6	2.4	0.1	0.9
Drug	63.2	53.1	67.4	85.8	75.4
DUI/DWI	4.1	34.4	7.5	0.8	5.9
Other	3.6	1.6	4.7	1.2	2.5
Drug Court Arrest					
Felony	65.2	63.5	-	96.8	59.7
Misdemeanor	34.8	36.5	100	3.2	40.3
Substance Abuse					
Ever Used (Lifetime)					
Alcohol	95.9	89.1	68.7	88.8	80.8
Marijuana	93.2	100	59.5	85.1	76.5
Crack/Cocaine	81.8	29.2	30.2	53.6	44.1
Amphetamines	5.0	58.9	67.5	19.7	43.7
Opiates	22.3	7.3	18.5	1.4	12.6
Other	38.2	24.0	10.4	14.1	16.9
Use Last 30 Days					
Alcohol	44.1	21.4	55.0	64.0	52.2
Marijuana	40.5	92.7	45.4	61.9	55.3
Crack/Cocaine	35.0	27.6	20.7	29.0	26.0
Amphetamines	0.0	13.5	51.3	6.2	26.4
Opiates	13.2	0.5	11.5	0.4	7.1
Other	6.4	6.8	9.0	2.7	6.5
% Prior Treatment Experience	48.2	27.1	17.8	37.5	28.2
Demographics					
% Male	80	79	46	72	65
% Caucasian	54	79	69	32	49
Mean Age	29	33	33	29	31
% High School Graduate/GED	37	63	25	52	40
% Employed at Admission	33	63	28	43	37

Compliance with Drug Treatment Court Requirements

The drug court model has as its primary intended intervention components of an effective substance abuse treatment delivery system, coupled with frequent and random drug testing, and regular status hearings and community supervision under the guidance of the court to ensure offender compliance. In addition to examining whether the treatment delivered to clients in these drug courts comports with the scientific evidence regarding effective substance abuse treatment, in this study, we also measured clients' compliance

with the various functional components of the drug court program where such data existed. The quality and availability of data varied by site, and by client records. The files did not contain information on the number of status hearings or the sanctions provided by the court in response to any negative behavior. The tables below summarize the core components of compliance with the programs' requirements (as could be assessed with the available data). Specifically, these data represent graduation rates, rearrest during the program period and post program rearrest (for 12 months past program discharge).

The multilayered drug court model intends to deliver an intervention that is structured, intensive and demanding for the addict-offender. In these four drug courts the typical offender participated in the following services once a week during the initial stages of the drug court program, generally for the first two months: 2 drug tests, two or three treatment sessions (for 90 to 120 minutes each), and one status hearing (except Creek County where the status hearing occurred bi-weekly). While the logic behind the structured intervention is compatible with the goals of assisting the addict-offender to become committed to recovery and to be held accountable for his/her behavior, while making progress in treatment, the results presented here suggest that the nature of the intervention as delivered is not sufficiently intense (in either treatment dosage or supervision by the criminal justice system) to ensure compliance or therapeutic progress. As a general rule of thumb, the researchers defined "adequate" compliance as the offender participating in 70 percent of the expected services. The 70 percent "rule" was employed as a tool to gauge how the offender was responding to the intervention and is admittedly a purely arbitrary criterion, but represents a plausible middle ground between being too strict or lenient of a criterion.

Table 5 displays the compliance for the offenders by the court's definition of successful completion status. Successful completion refers to the graduation from the drug court program as determined by the administrating judge and drug court team. Overall, relative to the number of offenders who participated in drug court programs, the percentage of offenders successfully completing ranges from 29 percent (Jackson County) to 47 percent (Bakersfield). Most surprising is the actual length of time that the offenders participate in the drug court program. Most drug courts have an expected length but often allow offenders to stay longer in the program if they are making progress towards dealing with their addictive behavior. In this four-drug court sample, it was common practice for offenders, both for successful and unsuccessful graduates, to participate in the program well beyond the expected program length (with a maximum duration of 44 months). The four courts frequently allow offenders that are having difficulty meeting program requirements to extend their time in the drug court program, only to then terminate the offenders "unsuccessfully" from the program. Across the four drug courts, this pattern occurred for over 22 percent of the cases of unsuccessful graduates. In some jurisdictions this means that the prosecutor can then reinstate the original charges and pursue prosecution of the offender due to an unsuccessful completion of the drug court program. Similarly 53 percent of the successful graduates of these drug courts participated in the program past the expected program length, suggesting that the 12 to 15 month time frame is generally too short to address the relapsing nature of addiction.

Table 5: Overview of Program Completion Rate and Time Spent in Drug Court by Graduation Status

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Total*	
Completion										
% Graduate	31.8%		48.4%		36.2%		29.0%		33.1%	
Expected Length	15 months		3,6,9, & 12 months		12 months		12 months		12 months	
	G	T	G	T	G	T	G	T	G	T
Total N	70	150	93	99	262	461	354	868	779	1578
Range (month)	9-42	1-44	3-33	1-36	6-33	1-42	6-45	1-43	3-45	1-44
Mean (month)	20.9	9.8	12.6	8.8	14.6	8.1	16.4	11.0	15.7	9.9
% Scheduled Time in Court										
26-50%	0	32.0	1.1	26.2	0.4	28.8	0.3	20.9	0.4	24.5
51-75%	12.9	22.0	9.7	12.1	3.4	16.7	2.0	18.6	4.3	18.0
76-100%	21.4	14.0	38.7	14.2	44.7	13.7	43.7	20.5	41.5	17.5
101-125%	4.3	0.7	11.8	7.0	21.7	4.5	15.0	6.0	15.9	5.2
>125%	61.4	14.0	38.7	15.2	29.8	11.1	39.0	22.6	37.9	17.9

G=Graduate T=Terminate

Besides variation in program compliance as measured by completion status, an analysis of the individual profiles of offenders finds significant differences between the types of offenders who are likely to successfully complete the drug court. In all sites, Caucasians are more likely to complete than African Americans or Hispanics. Graduates are also more likely to have higher educational backgrounds (high school diploma or above) than terminated clients. Users of cocaine/crack, amphetamines, and opiates are also less likely to graduate than users of marijuana.

Multivariate analyses were conducted to examine individual and program compliance factors on graduation from the drug court program (successful/terminated). In two sites (Bakersfield and Creek County), it was found that participants with a history of prior substance abuse treatment are less likely to graduate than participants who are receiving treatment for the first time. The second pattern that emerges concerns participants with three or more prior arrests. At the two urban locations (Jackson County and Bakersfield), it was found that participants with more serious criminal histories are also less likely to succeed in drug court. This pattern suggests that some drug court programs may have difficulty dealing with participants presenting more severe drug using and criminal behaviors.

Compliance with drug testing and attendance at treatment sessions varies considerably depending on the program completion status of the offender, as shown in Table 6 below. As expected those offenders that do not provide the requisite number of urine tests or that fail to appear for treatment sessions are more likely to be terminated from the program across each of the four drug court sites. Program terminators are two to three times more likely to test positive for illicit drug use during their drug court program participation than those who are successfully discharged. Regarding treatment sessions, most of the offenders whose cases result in termination are infrequent attendees of treatment sessions in all of the different drug court programs. Most surprising, in the Bakersfield Drug Court attendance at treatment sessions for graduates is very low (only 37

percent attend more than 70 percent of the required sessions) and these offenders are still allowed to graduate. A review of the compliance with treatment data illustrates that many offenders who successfully graduate are required to repeat various phases of the court program, with 27 percent of the graduates in treatment for 1.5 times the expected number of treatment sessions. The advantage of the drug court program is the flexibility to allow offenders that are making progress to extend their participation in treatment and then allow the offender to graduate. However, given relatively low completion rates (33 percent overall) this suggests that many offenders may be in need of a different type of treatment programming than is provided. (see qualitative study findings below).

Table 6: Overview of Compliance with Drug Test and Treatment Program Requirements by Site and Graduation Status

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Total*	
Completion										
% Graduate	31.8%		48.4%		36.2%		29.0%		33.1%	
Expected Length	15 month		3,6,9, & 12 months		12 months		12 months			
	G	T	G	T	G	T	G	T	G	T
Total N	70	150	93	99	262	461	354	868	779	1578
Drug Tests										
% Scheduled Tests Taken										
0-25%	0	6.8	0	35.7	5.4	44.7	0.9	31.1	1.8	31.7
26-50%	0	10.1	16.7	25.5	27.2	19.5	8.1	22.5	13.8	20.6
51-75%	0	18.9	28.2	21.5	27.2	13.6	21.2	14.5	21.5	15.4
76-100%	1.4	10.1	38.4	4.0	15.2	10.3	26.8	15.5	22.2	12.8
101-125%	8.6	13.6	12.9	8.2	3.3	4.7	21.5	6.7	13.7	7.2
126-150%	24.3	13.5	3.8	5.1	2.1	2.4	10.3	4.7	8.8	5.1
>150%	67.1	27.0	0	1.0	14.6	4.8	11.2	5.0	18.2	7.2
Meet 70% of required tests	100	69.6	57.7	17.3	43.5	25.6	75.7	34.7	67.2	35.3
% Participants Positive	57.1	81.9	52.6	89.8	53.8	60.5	63.9	88.5	63.9	81.4
Drug Treatment										
% Scheduled Treatment										
0-25%	0	11.7	0	16.2	0	41.1	0	73.5	0	45.6
26-50%	0	17.3	3.4	21.2	36.6	26.0	17.1	11.0	18.7	18.3
51-75%	2.9	17.9	14.6	30.3	31.4	19.2	12.2	5.7	19.4	15.2
76-100%	24.6	21.4	61.8	19.2	20.2	11.0	17.0	4.3	31.2	11.1
101-125%	18.9	14.5	15.7	8.0	8.5	1.7	22.0	3.1	13.9	5.1
126-150%	20.3	6.2	3.4	2.0	3.3	1.0	17.1	1.8	8.3	2.4
>150%	33.3	11.0	1.1	2.0	0	0	12.2	0.6	8.5	2.1
Attended > 70% Sessions	98.6	58.6	83.1	38.4	36.6	17.1	70.7	10.7	64.5	24.1

G=Graduate T=Terminate

Both the in-program arrest and post-program rearrest rates confirm that the predominate finding in other studies--successes succeed and failures fail--prevails. Of all of the participants, 14 percent of graduates and 42 percent of terminated clients were arrested during program participation (including the extended time, beyond 12-15 months that the offender remained in the program; technical violations such as failure-to-appear were not considered as a new arrests). As discussed in Tables 5 and 6, nearly all drug court participants are not in compliance with the overall conditions of the drug court regarding drug testing attendance and positive rates, attendance at treatment sessions, and other mandated conditions. In fact, an examination of the program duration for graduates finds

that 59 percent spend over the expected drug court time that indicates a fair degree of technical violations with program conditions.

Table 7: Within Program and Post Program Rearrest Rates by Site and Completion Status

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Total*	
Completion										
% Graduate	31.8%		48.4%		36.2%		29.0%		33.1%	
Expected Length	15 month		3,6,9, & 12 months		12 months		12 months			
	G	T	G	T	G	T	G	T	G	T
Within Program										
% Rearrests	9	15*	11	19*	21	73*	12	23*	14	42
Post Program										
% Rearrest in 12 months	6	21	11	39	13	53	7	38	9	41
Mean Length To Rearrest (months)	4.5	4.5	7.6	4.6	6.9	4.2	6.3	4.7	6.6	4.5

G=Graduate T=Terminate

Post-Graduation Recidivism Rates

The conclusions reached in reference to previous research on the effectiveness of drug court programs, specifically that "successes succeed and failures fail" continues in this data and in fact the trend continues past the time when participants graduate or are terminated from the drug court. In this study, rearrest data were obtained for each of the 2,357 offenders for 12 months past the date of discharge from the drug court program. As shown in Table 7 above, the trend continues with the terminated clients more likely to be rearrested for new offenses than the program completers. Rearrest rates varied by site, but overall 9 percent of those successfully completing the program and 41 percent of those discharged were rearrested for a new offense within twelve months. Terminated participants who were rearrested took an average of 4.5 months until rearrest whereas those successfully completing who were rearrested took about 6.6 months.

The results of a series of logistic regression models finds that discharge status (graduate/terminate) is the most consistent variable associated with post-program recidivism. In three of the four drug court, graduation reduces the risk of recidivism. No other variable is consistent across the four sites. In two sites, a within drug court arrest contributes to recidivism. The logistic regression model appears to confirm that "success breeds success" whereas failures do not do as well, even after termination from the drug court program.

Understanding the Dimensions of Drug Treatment Services

The second part of the study explored the nature of the drug treatment services delivered to drug court offenders to understand some of the results from the drug court participation. This section of the study involved the use of surveys and direct observations to quantify the services in a manner that can assist in understanding the treatment program

compliance and completion rates. A combined qualitative/quantitative methodology was used to explore the issues regarding the delivery of treatment services as they occur within the drug court setting.

General Counselor Characteristics

Counselor surveys were designed to gather information related to the characteristics of the counselors themselves, including their demographic characteristics, as well as their professional qualifications and typical responsibilities. Table 8 contains some basic information about this group of counselors working with drug-involved offenders. In general, counselors at these programs appear to have several years experience providing substance abuse treatment. The extent to which they had obtained advanced academic degrees varied by site, but was generally low. Similarly, varying proportions of counselors reported that they themselves were in recovery, with programs in three of the four sites employing at least some counselors in this category. The racial/ethnic background of counselors appeared to vary considerably, as did the average age of counselors employed at each site. Hispanic counselors were only employed in treatment programs at the California site. Counselors generally worked 30 to 40 hours per week, conducting between 3 and 6 group meetings (lasting from 6 to 8 hours total) per week. Across all sites, counselors reported that 41% percent of their time was spent in group or individual treatment tasks, with the remainder of their work time devoted to various administrative tasks (e.g., intakes, assessments, etc). Group size was generally consistent across sites at about 10 to 13 clients per group, while counselors' assigned caseload varied greatly from 25 per counselor to nearly 77 per counselor at different sites.

Table 8. General Counselor Characteristics

Counselor Characteristic	*St. Mary Parish*	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Respondents	3	3	21	8	38
(% Of solicited)	(50%)	(30%)	(65.6%)	(53.3%)	(54.4%)
% In Recovery	0	66.6%	38%	50%	40%
Modal Highest Degree Held (% w/modal degree)	BA (100%)	Ph.D., M.A.,<H.S. (1 each)	H.S. or less (48%)	BA (50%)	H.S. or less (40%)
Mean Years Providing Drug Treatment	4.0	2.5	4.7	6.1	4.8
Mean Age in Years	28.7	51.0	42.2	36.5	40.5
% White Counselors	33.3%	66.6%	19%	38%	28.6%
% African American Counselors	66.6%	33.3%	24%	25%	28.6%
% Hispanic Counselors	0	0	38%	0	23%
Mean Hours Worked per Week	40.0	27.2	40.3	30.0	36.8
Mean Number of Clients Assigned to Counselor	76.7	28.7	34.3	25.0	35.3
Mean Weekly Number of Groups (Hours/Week)	3.0 (6.2 hours)	5.7 (8.0 hours)	4.7 (8.2 hours)	4.3 (6.8 hours)	4.5 (7.6 hours)
Mean Clients per Group	13.5	9.7	10.1	13.1	10.9

†- Data is from counselors who responded from all five of the programs examined at this site.
‡ - Data is from counselors who responded from both of the treatment programs at this site.

Counselors' Philosophies of Drug Abuse and Effective Treatment

The survey instruments also asked the counselors to rate their agreement with several statements intended to capture information about their perspective on the likely causes of drug use and abuse, as well as their opinions about what components were needed for effective substance abuse treatment. Counselors rated their agreement with each of these statements using a five-point Likert scale ("1" = "strongly agreed with the statement", "5"= "strongly disagreed with the statement"). Each of these items was then aggregated into scales representing specific theories (e.g., Social Learning theory, Social Disorganization theory, etc). The average score, by site for all items on each of these theoretical "causation of drug abuse" scales are presented in Table 9.

Counselors at all sites tended to moderately endorse the disease model, cognitive-behavioral skills deficits, psychopathic personality characteristics, antisocial values, social learning theory, social control theory and labeling theory as important causes of drug abuse. They tended to slightly disagree with items representing conflict and social disorganization theories, and generally had no opinion on strain theory as a cause of substance abuse. These results suggest that as a group these counselors tended to locate the causes of drug abuse within the personalities and individual experiences of the drug user, more so than as a result of external, macro-level social influences.

Table 9. Mean Scores for Counselors' Philosophy of Drug Use Causation
(1=Strongly Agree, 5=Strongly Disagree)

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Drug Use Cause Scales					
Conflict	3.4	3.5	3.2	3.5	3.3
Labeling	3.0	2.7	2.5	2.5	2.5
Social Control	2.6	2.8	2.2	2.2	2.3
Social Disorganization	3.7	3.1	3.2	3.4	3.3
Social Learning	3.0	2.0	2.1	2.4	2.3
Strain	2.9	3.3	2.8	3.5	3.0
Anti-social Values	2.4	2.9	2.5	2.7	2.6
Cognitive Skills Deficits	2.0	2.0	2.0	1.9	2.0
Disease Model	1.7	3.5	2.1	2.1	2.1
Psychopathy	2.5	2.8	2.1	2.5	2.3

†- Mean response for each scale is presented for responding counselors from all five of the programs at this site.
‡ - Mean response for each scale is presented for responding counselors from both treatment programs at this site.

In terms of the important components of effective drug treatment the counselors tended to moderately endorse items representing nearly all of the scales (see Table 10). This pattern of results suggests that this sample of drug court-involved counselors tended to support a diverse and eclectic approach to treatment, apparently being willing to apply almost any technique in an attempt to reduce drug use. It may also suggest that they do not generally have a strong affiliation or understanding of any particular approach to treatment, or that they do not implement a coherent treatment strategy in their programs. Given that the treatment providers in only one of the courts use a formalized curriculum in their treatment programs, it is not surprising that many of the counselors involved in these courts do not have a clearly defined idea of the important components of substance abuse prevention.

Table 10. Mean Scores for Counselors' Philosophy of Effective Components
(1=Strongly Agree, 5=Strongly Disagree)

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Effective Component Scales					
Conflict	1.4	1.8	1.8	2.2	1.9
Labeling	1.3	1.3	1.5	1.6	1.5
Social Control	1.0	1.6	1.6	1.4	1.5
Social Disorganization	1.8	1.8	1.9	1.9	1.9
Social Learning	1.8	1.7	1.5	1.3	1.5
Strain	1.6	1.5	1.5	1.2	1.4
Anti-social Values	1.8	1.8	1.6	1.4	1.6
Cognitive Skills Deficits	1.6	1.7	1.6	1.3	1.5
Disease Model	1.8	2.8	1.7	1.8	1.8
Psychopathic Character	1.8	2.8	1.9	2.3	2.1

†- Mean response for each scale is presented for responding counselors from all five of the programs at this site.
‡ - Mean response for each scale is presented for responding counselors from both treatment programs at this site.

Observation of Treatment Services

Table 11 presents information representing the proportion of all observed meetings in which any item from each category of treatment intervention occurred. For example, at the Bakersfield site (with five separate treatment programs observed) on average, only about 22 percent of the observed meetings contained any discussion of cognitive-behavioral components. In fact, despite the vast literature demonstrating the effectiveness of cognitive-behavioral treatment components for dealing with substance abusers in no site did more than 22 percent of the observed meetings include these treatment components. Items in the education/aftercare category (mostly informational-type components, such as teaching clients the basic concepts and vocabulary associated with treatment or the impacts of various drug classes) were also relatively rarely employed in these programs. Similarly, items drawn from the Alcoholics Anonymous (i.e., Disease Model) and Therapeutic Community Models (e.g., confrontation, the reliance on peers as the agent of change) were also relatively rarely employed (in less than 20% of meetings).

Finally, treatment components aimed at creating a safe (physically and psychologically) environment for clients, as well as those fostering self-exploration were somewhat more commonly employed, particularly in the programs operating in two sites where these items occurred in only about 25 percent of observed meetings. Consistent with the results from the philosophy of effective treatment intervention scales, it appears that the counselors in this sample of drug courts were employing a relatively wide range of treatment activities in serving their clients. On the other hand, the cost of this diversity in treatment components appears to be that most topic areas are dealt with sparingly. Most importantly, as shown in Table 11, the material is presented in a largely superficial and brief manner.

Table 11. Observation of Treatment Meetings
(Percent of Meetings Observed Containing at Least One Item from the Category)

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
% Meetings					
Cognitive-Behavioral Items	19.5	16.8	22.4	15.3	18.5
Education and Aftercare Items	7.2	5.5	10.2	5.1	7.0
Safety and Self-Exploration Items	21.8	14.8	26.1	12.2	18.8
12-Steps (AA/NA) and Therapeutic Community (TC) Items	14.3	6.9	13.2	19.7	13.5

†- Data is presented from the average of five treatment programs at this site.
‡- Data is presented from the average of two treatment programs at this site.

Results presented in Table 12 are consistent with the idea that these programs employ a multi-faceted, yet superficial approach to treatment. In fact, these results suggest that this group of counselors are not only dealing with a wide range of treatment issues in a "broad-based" manner, in terms of how frequently their meetings focus on each group of topics, but also in terms of the amount of time in a given meeting that is spent on any particular topic when it is addressed. For instance, among all observed meetings at the five treatment programs operating in association with the Bakersfield court, the average amount of meeting time spent on cognitive-behavioral components was 11%. Thus if the average meeting length at the five programs in Bakersfield was one and a half hours, clients in these meetings would have spent approximately 10 minutes discussing cognitive-behavioral treatment components (when they discussed them at all, again only about 20% of the meetings dealt with this set of issues at all). Creek County spent the most time addressing cognitive-behavioral components (26% of the meeting time in meetings where CBT occurred); but, as indicated in Table 11 it is important to note that only about 17 percent of the meetings in Creek County contained any discussion of CBT components. In general the treatment topic area that received the most intense discussion, when it was presented, was the education/aftercare area. Again these represent informational type items, such as reviewing treatment-related concepts and terms or discussing plans for accessing services after participation in the drug court. These items do not generally represent the more intense or involved treatment components (and they were among the more rarely occurring items in terms of the proportion of meetings in which they were observed, see Table 11).

Table 12. Observation of Treatment Time
(Percent of Treatment Time Spent on Items in the Category)[a]

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
% of Time					
Cognitive-Behavioral Items	8.2	26.5	11.1	16.6	15.6
Education and Aftercare Items	30.5	42.7	27.0	27.3	31.9
Safety and Self-Exploration Items	13.7	8.6	15.2	14.5	13.0
12-Steps (AA/NA) and Therapeutic Community (TC) Items	6.0	7.2	3.5	12.4	7.3

a – Time spent on topics rated as "other" are not included in this table, nor is time spent on breaks taken during the groups' scheduled meeting times.
†- Data is presented from the average of five treatment programs at this site.
‡- Data is presented from the average of two treatment programs at this site.

Discussion and Implications of the Findings

The drug treatment court model is a complex programming strategy that relies upon criminal justice and treatment actors to deliver well-integrated services within the court, supervision, and a treatment arena that emphasizes the importance of recovery as a means of reducing criminal conduct. Part of the drug court process is to develop a consensus among stakeholders about the value and importance of treatment as a tool to improve offender outcomes. Great strides have occurred as drug courts have evolved and grown exponentially (Cooper, 2001; Goldkamp, White & Robinson, 2001). Even more importantly the drug court environment has assisted in the growing realization that effective interventions that combine treatment and sanctions can address the behavioral problems of drug-addicted offenders. Prior studies and reviews have documented the benefits from drug courts with the emphasis on improved outcomes of offenders in terms of treatment completion rates, reduced substance abuse, and reduced recidivism.

This study was designed to explore the concept of treatment integration in four drug courts that are considered to be "mentor" courts. These courts have strong leadership from the judiciary who originally lead the way for the creation and growth of the drug court model as a tool to deal with the relapsing behavior of drug offenders. The study conducted a retrospective analysis of 2,537 offenders that participated in the four drug courts to examine the relationship between treatment quality and program compliance and program completion, in-program and post-program recidivism. The analyses presented here add to a small but growing literature on the impact of offender characteristics and program components on outcomes (Goldkamp, White, & Robinson, 2001; Gottfredson, Najaka, & Duran, 2002; Harrell, Cavanaugh, & Roman, 1989), which in the case of drug courts is still inconclusive in response to the question of "does it work?" This study adds to the existing literature by examining both in-program and post-program recidivism. In addition to the retrospective analysis of client outcomes is an exploratory study of the nature and quality of treatment inside the drug court. Using a combination of surveys, interviews, and observation of treatment sessions, we examined the type of services delivered to the drug court offenders in each of the four sites. These combined methods were used to begin exploring the issues related to integration of treatment within the drug court environment and the types of services provided to the offender.

Several limitations of this study deserve recognition because they may have important impacts on the confidence of the findings. First, the overall design of this study does not include any comparison or control groups with which to compare drug court client outcomes. Instead, the study compares the drug court services, utilization of these services and rates of recidivism across the four different courts, two in rural settings and two in urban settings. Furthermore the comparison is made between courts that provide treatment services as a referral to the local treatment systems or courts that provide more direct, contracted services for drug court clients. The lack of a control or comparison group obviously limits the findings from our study, and does not address some of the methodological issues that have been raised by Belenko (1998, 1999, 2001), Goldkamp, White and Robinson, (2001); Sherman, et al., (1997), and Taxman (1999).

Second, results of this study were generated with the relatively limited data available at each site. The most notable impact of the limited availability of information is the lack of data on the number of status hearings attended or sanctions imposed, two of the main ingredients of the drug court model. None of the four sites maintained this information in a manner that was readily available to the evaluators. Thus, the study does not adequately examine some of the core functional aspects of the drug court, sanctions and judicial interactions. Another limitation is the treatment participation rates among drug court participants. In all of the sites, the courts do not maintain records of offenders that are screened, , but do not participate in drug court. The records merely reflect those that volunteer, and then offenders that begin to participate. The records do not allow for an analysis of differential participation rates for drug court and drug treatment separately.

Finally, the data from the retrospective analysis and the exploratory study do not necessarily represent the same cohort of offenders. In the retrospective analysis, we needed a sufficient time period to allow the offenders to progress through the drug court. And, as the findings illustrated, we needed at least a 24-month window given the tendency in these four courts to extend the duration in drug court to adjust to the relapsing behavior of offenders. The time-frame of our funding from the National Institute of Justice would not have allowed for this window. The exploratory study of the nature and quality of treatment services delivered was structured as a single, cross-sectional snapshot of the treatment services employed in the courts. Anecdotally, most of these courts had relatively stable relationships with their treatment providers and the courts themselves had each been in operation for several years prior to this study. However, the possibility exists that variations in treatment type and quality has occurred over the period of time (several years) covered by the retrospective analysis of participant level data. Given the exploratory nature of the study overall and these specific limitations, the ability to make definitive statements about the impact of these specific types and amounts of substance abuse treatment services on outcomes is admittedly compromised. However, this study does provide a vehicle to identify possible hypotheses and research questions that could guide the next generation of studies focused on the effectiveness of specific drug court components (originating from both the criminal justice and treatment systems).

The findings from this study should be interpreted cautiously regarding whether offender characteristics or level of programmatic utilization influence in-program outcomes (e.g. graduation, rearrest, etc.). The findings suggest that it is likely that program compliance affects program completion and recidivism but it is equally plausible that these findings could be the result of selection bias. Many offender characteristics were not available in the data sets provided by the drug courts that may be pertinent to the analysis. Comparisons between graduates and terminated clients on race, gender, age, prior criminal history, and prior substance abuse suggest some differences among the groups that may account for the likelihood to graduate. But many unmeasured independent (e.g. motivation, severity of use**,** etc.) and intervention variables (e.g. duration of treatment, clinical progress, sanctions imposed, etc.) may also account for these differences. Furthermore, the tendency of the drug court to continue involvement in drug court for those having compliance problems suggests that the concept of "graduation" is inadequately defined, measured and understood.

Even with these constraints, this study has been illuminating about drug courts and drug court operations. The drug court concept is one that requires all parties to coordinate services in a manner that is unique in most criminal justice program agencies. In each of these four drug courts, the result has usually been that the treatment agency is asked to deliver much of the direct support and clinical services—testing and treatment. The court is responsible for supervision and sanctions. The interviews with stakeholders and the review of data collected in each of the four sites suggests that despite its intention to provide a thorough integration of services, the drug court is more about "coordination" of services—linking services together from existing resources, rather than integrating services within a framework where there is increased scrutiny and demands from other agencies. In each domain of the drug court, whether it is treatment, testing, sanctions or supervision, the tendency is to allow the organization primarily responsible for the service to deliver it as they see "fit".

None of the drug courts adopted any set policies or standards that would promote a well-integrated model (i.e., cooperation and joint-decision making across agency boundaries). Thus, the judiciary delivered sanctions, but these sanctions tended to be "individualized" to the needs of the offender instead of having any set standards or units of care consistent with the principles of contingency management systems or compliance management systems (Taxman, Soule, Gelb, 1999). Treatment, regardless of whether it is contracted out or brokered from among existing services, is run and administered by the treatment system with little input and oversight by the other members of the drug court team (e.g., judges, supervision staff). Testing is the responsibility of the treatment system for the most part, and supervision and case management is left to the separate administering agencies.

The analysis suggests that program completion rates are relatively low ranging from 29 to 48 percent. This is on par with or slightly lower than the typical outpatient drug treatment program as determined by a nationwide study of outcomes from drug treatment programs (Simpson, et al, 1997). It is apparent that program compliance varies considerably but few offenders are in total compliance, in terms of attendance at requisite treatment sessions or maintenance of a drug-free status. The surveys of treatment providers mirror the findings from the Drug Abuse Treatment Outcome Studies (DATOS) sponsored by the National Institute on Drug Abuse where the researchers found that treatment providers tended to offer "eclectic" and a theoretical services (Simpson, et al, 1997; Etheridge, et al, 1997; Simpson et al, 1999). Few offered programs that were consistent with good quality cognitive behavioral services. The surveys revealed that the treatment providers tended to be in recovery and did not have advanced training. Even though half of the programs had formalized curriculum, there was not a clear theoretical consensus among the counselors as to the causes for the addiction disorder or the best tools to provide clinical care. Both of these suggest that the treatment counselors are not following a prescribed formula for delivering services. This was apparent in the observations where the typical group therapy session consisted of a range of administrative, clinical, and support activities. The sessions were more focused on information sharing rather than skill building.

Given the observations of the group sessions by the researchers, it seems plausible that some of the attendance problems for treatment sessions observed in the retrospective analysis may be due to the poor quality of services provided, the offender's perception that the services are not beneficial, or the offender's low level of satisfaction with the services provided. Regardless the observations and surveys confirm that there is a need for better management of the clinical services and better quality control. Such administrative actions may actually ameliorate some of the perceived issues with offender motivation to attend clinical sessions.

Within program and post program rearrest rates among these drug court offenders suggest that the programmatic components may not be affecting behavior. The within program arrest rates, coupled with the low completion rates for the drug court program overall, suggest that further well-designed studies are needed to understand the impact of offender characteristics and functional program components on drug court outcomes. This study cannot answer the question but it does appear that even drug court program graduates fail, although their failure rates are less than terminators. However, some selection bias may be occurring in both who is defined as a graduate and the types of individuals that ultimately graduate.

The retrospective study revealed some patterns in the drug court regarding program length of stay that have yet to be discussed in prior studies. In each of these four drug courts, the courts frequently extended the drug court time period. Presumably this is due to compliance problems and positive drug test(s) but the data available for this study only allows us to postulate this as a possible explanation. Regardless, 53 percent of the graduates and 23 percent of the terminators were in the drug court for more than the expected program length—some for up to twice as long. This suggests the potential for net widening, particularly for the terminators where the prosecution may decide to reinstate the original charges or incarcerated for program noncompliance. But it also suggests a warning sign for the graduates since the criteria for making a determination about graduation may be dependent on attitudes and values of individual judges or program staff instead of set program criteria. The graduates may also be in jeopardy for negative consequences unless the drug court program adopts set standards for program completion for the variety of relapse patterns of offenders.

Conclusion and Future Research

Drug courts offer promise to the integration of treatment within the criminal justice setting. This study reveals that drug courts are moving in the direction of, but have yet to fully reap the benefits that it often acknowledges—namely the use of drug treatment as a means to reduce drug use and criminal conduct on the part of drug offenders. The drug treatment court concept requires attention to the value of different programmatic components. But there is more to be learned about the service delivery system, and how these services affect recidivism, reduced drug use and employment. More specifically future research studies on drug court model need to gain a better understanding of the values and perspectives of the drug court team—judges, prosecutors, defenders, supervision staff, treatment counselors, and others—on the services provided and the

components of effective interventions. Related is the issue regarding the sanctions imposed for different types of infractions and behaviors, and how treatment is intertwined in the sanctions. In this study, it appears that treatment participation was extended but it is unclear as to the circumstances that lead to this extension or the nature of the services provided. In fact, a better understanding of the use of different treatment services for different types of behaviors is warranted given the compliance issues exhibited by the offenders in these four courts. Finally given the issues raised in the exploratory study there is a need to examine the offender's perception of the treatment services provided and the value of these services in gaining skills to achieve recovery and abstinence. This next generation of studies should be devoted to answering the question "what part of the drug court program works, and for whom" instead of focusing merely on the question of "does it work?"

Chapter 1

Introduction

Overview

For nearly thirty years, the criminal justice and drug treatment system have struggled with a structural process to provide timely access to drug treatment services for offenders. For years, criminal justice agencies have addressed substance using and abusing offenders by offering and/or requiring participation in programs designed to address their deficits. More often than not, the majority are referred to local substance abuse and/or mental health agencies that provide outpatient care upon release. Few offenders were offered services while incarcerated and few programs had long term success. In response to the need to provide drug treatment services, jurisdictions have created a number of innovations including case management services to advocate for services for offenders (e.g. Treatment Alternatives to Street Crime), specialized in-prison or in-jail treatment programs, specialized probation or day reporting programs, and diversion programs. Studies on the efficacy of such innovations have mixed results, with some programs reporting reductions in recidivism and others not (Sherman, et al, 1997; Anglin, et al, 1996; MacKenzie, 2000; Taxman, 1999). One theme echoed in many of the studies is that the overall operations of treatment and treatment services for offenders has not been affected by these innovations, and treatment services for offenders remain scarce (Duffee and Carlson, 1996). Overall, few systemic effects have been realized and programs consistently struggle with ensuring the stability of treatment services as resources increase and decrease. Estimates are that of the 45 percent of the offenders who are in need of drug treatment services (ADAM), only a mere token of these offenders receive any services, and often these services are mismatched with the needs of the offender (Farabee et. al., 1999). Further, while the drug treatment innovations appear to provide a limited linkage between the treatment and criminal justice system, many analyses continue to suggest that the services are not integrated into the operating philosophy of the criminal justice programs.

Drug treatment courts evolved as a new innovation in 1989 in Miami, Florida as a means to overcome the often-inconsistent participation and delivery of treatment services, and to integrate treatment into the normal, daily operations of the court and supervision systems. The drug treatment court includes treatment, drug testing, supervision/oversight, and compliance management with the specialized feature of the presiding judge overseeing the progress of the addicted offender. The judiciary provides a routine basis to ensure compliance with both treatment and punishment conditions. The drug treatment court is novel in that the judiciary maintains the integrity of the drug treatment court design by ensuring that all components of the program are integrated. In many ways, the concept of the drug treatment court reshapes criminal justice policy by forging the interdisciplinary team to address the addiction and criminal behavior of offenders through integrated programming and through the altered role of the judiciary.

Drug treatment courts rapidly expanded during the last decade to nearly 700 courts. Funding from the U.S. Department of Justice, and the creation of a specialized Drug Court Program Office in 1994, contributed extensively to the growth of the drug court movement. The availability of planning and implementation funds from the federal government provided the impetus for many jurisdictions to consider the drug treatment court. The drug treatment court is also perceived as being different from other "alternatives to incarceration" due to judicial involvement, prosecutorial role, and access to treatment services. By design, the drug treatment court places equal emphasis on treatment and public safety in the programming for the addicted offender.

The underlying rationale for the drug treatment court centers on drug treatment goals, namely reduction in drug use, as a primary goal of the criminal justice system and that treatment intervention is important in order to achieve this goal. Stated simply, drug courts recognize that treatment is one of the primary interventions to achieve justice goals and the role of the court is to ensure that these services are provided.

Drug courts provide a programmatic process to address addiction as a chronic behavior with relapsing occurrences. The traditional justice system has struggled with responding to reoccurring *behavioral* conditions due to it's tendency to be incident-driven and the use incarceration as a potential response. Under the traditional system, little tolerance exists for the reoccurring nature of addicted behavior and the criminal justice system continues to struggle with providing appropriate and proportionate responses for non-compliant behavior. Under the drug court model, frequent status hearings provide positive reinforcement for the struggling addict as well as a means to respond to potential relapsing incidents. The drug court process recognizes the relapsing nature of addiction, and provides the flexibility to respond accordingly. Therein lies the major difference between the drug court and the traditional treatment process for offenders—the integration of treatment goals within the fabric of the drug court process.

The drug court concept, as implemented in a variety of settings, provides the opportunity to explore how treatment is integrated into the drug court setting. More importantly, key questions have to do with the organizational and structural delivery of services in a manner that reinforces the importance of treatment goals (e.g. retention in services, reduced drug use, etc.) along with justice goals. In other words, how are drug treatment services provided within the framework of the drug court? What policies and procedures drive the drug court that recognizes the importance of treatment? The available literature on drug treatment courts does not address these questions, particularly the issues related to how treatment services are offered to offenders. Nor does it address what are the supporting policies and practices of the drug treatment court that reinforce the goal of providing drug treatment: *to reduce the recidivism of drug involved offenders by changing their drug using habits*. We intend to examine these issues in this report as part of an exploratory study on the delivery of treatment services within the criminal justice system.

In this chapter we will address some of the common issues related to drug treatment courts based on findings from the research literature. This chapter reviews the effectiveness of drug treatment courts, describes the processes and activities that occur in the drug treatment court, reviews the key ingredients of their success, and outlines the research questions that will be addressed in this study.

Drug Treatment Courts: The State of Knowledge

The decade of the 1990's was one where drug courts thrived, but studies of drug courts did not occur at the same pace. As noted in two annual reviews of drug courts, few studies use rigorous designs, which limits conclusions that can be drawn about the efficacy of drug courts, compared to other innovations (Belenko, 1999; 2001). Some studies report findings to support reductions in judicial dockets, caseloads, jail bed days, police overtime, and system costs, although many of these studies do not have adequate comparison groups, which makes the findings less valuable. At the offender level, within-program reductions in drug use are reported, but again these studies are limited to the nature of the design and small sample sizes.

In two comprehensive reviews of drug court research, Belenko notes that the findings tend to support four major conclusions about drug courts:

- Offenders with more serious criminal history or originating charges are participating in drug courts more than previous innovations.
- Drug use while in drug court among program participants tends to be lower than drug use in other programs
- Graduation rates from drug court tend to be higher than graduation rates from outpatient drug treatment programs, although it is unclear how offenders perform in outpatient drug treatment programs
- Re-arrest rates during drug court program participation period are lower than rearrest rates for other offenders that are not in drug court.

The general findings tend to support that the drug treatment court is providing an avenue for drug using offenders to participate in drug treatment, and that as the model is developed and implemented it is likely that results can be achieved for serious drug offenders.

One of the few experimental studies on drug treatment courts was conducted in Baltimore City, Maryland and supports Belenko's general conclusions, but provides a more complete picture of the contribution of different drug court-related services that offenders receive and the impact on offender outcomes. In this study, the researchers randomly assigned 139 offenders to drug court and 96 to traditional supervision from February 1997-August 1998 (Gottfredson, et al. 2002). The average age of the offender was 34 years old, 74 percent were male, 89 percent were African Americans, and the mean number of prior arrests was 12. The offenders participating in the study represent the complex offender pool of severe substance abuse and criminal history. Of the 139 offenders assigned to drug treatment, 67 (48 percent) received some type of treatment services (predominately outpatient or intensive outpatient services) and 72 (52 percent) received no clinical treatment services at all. For those offenders that participated in treatment, the average drug court offender was in drug treatment for 199 of the 423 supervised days, or a rate of 47 percent of the time involved in drug court. At least one status hearing was provided to 81 percent of the drug treatment court participants.

More importantly, the researchers explored the impact of some differential program components on offender outcomes and found that offenders involved in the drug treatment court have lower re-arrest rates than non-drug court participants. The rearrest rate for those assigned to the drug treatment court is 66.2 percent over a 24-month post assignment as compared to 81.3 percent for the control group ($p<.05$). The average number of months to rearrest for drug court participants is 11 months, compared to 5 months for the control group. While the main effects illustrate the efficacy of the drug court model, an analysis of the services provided within the group randomized to drug treatment court provides a slightly different picture. Differential rearrest rates occur for drug court participants based on the acquisition of treatment services. Offenders receiving drug treatment services (48 percent of the sample) had a 56.7 percent rearrest rate compared to 75 percent of the offenders who did not receive drug treatment services. Further, the study found that offenders who received treatment and supervision in the drug court were more likely not to fail than drug courts offenders receiving neither services. The study confirms the importance of drug treatment as a critical component of the drug court and the linkage that providing treatment services has to offender outcomes. Turner and her colleagues conducted a 36-month follow-up study on the Maricopa County First Time Drug Offender (FTDO) program. This study found that 77 percent of the offenders participating in drug court received drug treatment. In this study, the drug treatment group also had a lower rearrest rate (33 percent) compared to the control group (44 percent), although the researchers do not report the differential rearrest rate for the drug court offenders based on participation in drug treatment. Discussions with these scholars confirm that offenders participating in drug treatment services had lower rearrest rates than others (Turner, 2002). However in this study, a small sample of interviewed offenders revealed that they had an easier time completing drug treatment court requirements than other probation requirements such as community services and payment of financial conditions. Little information was provided on the value of the treatment services.

Drug Treatment within the Drug Treatment Court Setting

While it is assumed that drug treatment courts would include drug treatment services, the provision of such services within the drug court setting is largely unknown. In fact, few studies have been conducted to examine the organizational and structural issues related to the provision of drug treatment services. The limited studies have found some conflicting stories about the access and availability to drug treatment services for the drug court, suggesting the need for more research into these linkages.

In 1999, a survey of 212 drug treatment courts was conducted by the Treatment Accountability for Safer Communities Programs (TASC), with funding by the Office of Justice Programs and Substance Abuse and Mental Health Administration. While the survey findings report that 'treatment services designed for and used by drug treatment courts comport with scientifically established principles of effective interventions" (2001:xii), Taxman and Bouffard in reviewing the survey results note that the "linkages to the treatment system appear for the most part to be compartmentalized." (Taxman & Bouffard, 2002). The treatment services offered in the drug treatment court reflect the services available through the general substance abuse treatment community instead of

being tailored to the needs of the drug-involved offenders. For example, 51 percent of the survey respondents do not have formal placement criteria for determining level of care needed for the participant. This lack of ability to match the participant with the level of care needed is typically the result of a treatment system that lacks an array of services. Nearly 61 percent of the courts report having dedicated slots in specific residential, detoxification and methadone maintenance programs, which are a small percentage of the available services. While the survey finds that courts admit to access to a wide variety of services, this array is not typically available when needed.

Turner and her colleagues at RAND in a process study of 14 drug treatment courts note that "access to a continuum of alcohol and drug user treatment services and other related rehabilitative services was often difficult, reflecting financial issues, as well as lack of coordination and information flow between treatment providers and other drug treatment court staff" (Turner, et al., 2002:1505). In this study, the researchers found that the linkages between the drug treatment court and drug treatment system tends to be characterized by informality where the court accesses available services but the drug treatment court and services are not integrated. While informality does not suggest that the services do not address an offender needs, it does address the lack of policy and operational practice that has developed to address structural issues regarding organizational barriers and impediments. In particular, the researchers note that referral and communication among the treatment providers and criminal justice system in these 14 drug treatment courts is still in its infancy, with the tendency for coordination to occur on an "as needed" basis. This characterization may be reflective of the early developmental stage of the drug court but it also suggests that drug courts have not necessarily built the interdisciplinary team case management approach as recommended by the National Association of Drug Court Professionals or the Office of Justice Programs. More importantly, the researchers found that there was still some tension between supervision and rehabilitation objectives in some drug treatment courts. These tensions generally resulted from the quality vs. quantity problems that affect drug courts where the push is to serve a larger number of offenders than funds allow to be served. Usually this results in short-changing some of the services that addict-offenders need to maintain their sobriety and crime-free lifestyle.

Taxman and Bouffard (2002), using the survey data from the TASC survey of 212 drug courts (see above), confirm some of the disconnects between the delivery of treatment services and drug court operations. Although the survey reported that drug courts engaged principles of best practices, the results suggest otherwise. In key areas, the drug court respondents highlight the lack of policy and operations that underscore the drug court program in that jurisdiction. For example, drug courts tend to target offender's eligible for drug court by the offense and criminal history instead of the substance abusing behavior. Half of the drug courts report that they have non-clinical staff screen for eligible clients for the drug treatment court, and nearly 60 percent of the drug treatment courts exclude offenders from participation because they are not motivated for treatment. Half of the drug courts do not have any formal placement criteria to determine what type of treatment services the offender should receive, and case management services are not uniformly delivered in a team manner and infrequently are provided by the drug treatment court. Many of the courts have more than one agency conducting drug tests (e.g., treatment provider, probation, etc.) and often the results are

not shared. While drug courts are designed to integrate services across systems, it appears that few courts have developed such an approach. This raises many unanswered questions about the treatment services provided to offenders in the drug court setting and the impact of such services on outcomes.

Purpose of this Study

Drug treatment courts are the nexus between the criminal justice and treatment systems. They provide a programmatic means to integrate services—supervision and treatment—to reduce the substance abuse behavior of addict-criminals. Therein lies the premise underlying the drug treatment court—that the court can become an effective modality to provide the offender drug treatment services, to provide the leverage necessary to insure participation in drug treatment and achieve abstinence, to provide swift and certain negative sanctions for negative behavior, and to provide the addict-offender with some time to adjust to treatment, testing and sanctions. The drug treatment court changes the organizational dynamics by providing a mechanism to facilitate behavioral change that is theoretically sound; treatment combined with structured sanctions and rewards is consistent with the effective interventions.

The questions that have not been addressed by current research studies are how the treatment and criminal justice system have developed in the drug court setting. In this report we set out to address these questions through a thorough assessment of the treatment delivery system in four "mentor" courts. Mentor courts are designated by the National Association of Drug Court Professionals (NADCP) to be mature courts that have evolved. To examine the issues, the following research questions will be addressed:

- What types of treatment services are offered in the drug court setting?
- Is the treatment delivery system integrated into the drug court setting?
- How do the philosophies and interventions of treatment counselors coincide with the goals of the drug treatment court?
- What impact does participation in drug treatment have on outcomes for drug treatment court participants?

The following study will address these and other issues related to the provision of treatment services within the drug treatment court.

Chapter 2

Research Design and Methodology

Overview

The purpose of the study is to examine the efficacy of treatment modalities on adult drug courts. It provides both an examination of current treatment practices and services delivered to drug court participants and provides a retrospective analysis of participant level data over a four-year period. A correlation between current treatment practices and the retrospective portion of the study assumes that treatment practices have not changed over time.

The fieldwork was conducted over a thirteen-month period beginning in February 2001 with the first site visit in Bakersfield, California and ending with the second site visit to the Jackson County, Missouri drug court in February 2002. Information about the four drug court programs, their affiliated substance abuse treatment services, and participant records were obtained over the course of two or more site visits. During these visits, key staff responsible for court operations and the delivery of substance abuse treatment services were interviewed, the delivery of substance abuse treatment sessions was observed, and information about drug court participants was obtained from treatment and court records.

The research employs both quantitative and qualitative techniques. The retrospective portion of the evaluation consists of an analysis of 2357 drug court participants who completed the program through termination or graduation. Participant level records were obtained from both treatment and court records, and criminal history and recidivism data was obtained from the National Crime Information Center (NCIC). The qualitative portion of the research consists of interviews with criminal justice and treatment personnel involved in drug court operations, surveys of treatment counselors as well as direct observations of treatment delivery. Overall, fourteen treatment administrators and twenty court staff were interviewed. A total of 90 questionnaires were sent to treatment counselors and 52 (57.8%) were completed. And, a total of 124 treatment sessions were observed.

The chapter is organized as follows. The next section provides an overview of the site selection process. This is followed by descriptions of each data collection technique, including the relevant procedures used to administer them.

Site Selection

The research examined treatment services and organizations involved in drug court operations across four jurisdictions: Bakersfield, California; Creek County, Oklahoma; Jackson County, Missouri; and St. Mary Parish, Louisiana. The four sites were selected after an examination and survey of the substance abuse treatment components of drug courts across the country. Emphasis was placed upon selecting sites that were considered more mature, had served as mentor drug courts, and where the same treatment providers

had been providing services to drug court participants for two years or more. Site selection emphasized a broad range of geographic and socio-economic differences in conjunction with varying levels of treatment components.

Specifically, the four sites selected include a drug court that is a single-site court with multiple treatment providers (Bakersfield, California), a multi-site drug court with a single treatment component (Jackson County, Missouri) and two single-site drug courts with one treatment component (Creek County, Oklahoma and St. Mary Parish, Louisiana). Site selection includes drug courts from two rural communities (Creek County, Oklahoma and the St. Mary Parish, Louisiana) and two urban areas (Bakersfield, California and Jackson County, Missouri). (See Chapter 3).

Administrator Surveys and Interviews

Chapter 5 – Each treatment program administrator was given a survey to obtain information on the operation of the program, its organizational structure, funding sources, array of services, staffing levels, client characteristics, and so on. (See Appendix A for a copy of this protocol). Administrators were asked to complete the survey and return it to the researchers during the site visit. The researchers also conducted an interview with each treatment program administrator, which is further described below. During this face-to-face interview, the administrator was also given the opportunity to seek clarification on any of the survey items that may have been unclear. In some instances the administrators were allowed to mail the completed survey to the researchers at a later date in order to locate some of the detailed information (e.g., distribution of clients across racial categories) being sought. Administrators were also asked to complete an informed consent form for this survey and the administrator's face-to-face interview. This consent form was similar in content to the one employed for the Treatment Staff Surveys, with the exception that administrators were not offered compensation for their time in completing the interview and survey.

Interviews were conducted with program administrators at each site with each interview lasting approximately one hour. During this time the researcher was able to clarify any issues regarding information collected from the Administrator Survey and also to solicit additional information on such issues as the use of drug testing, provision of aftercare services, and communication with the drug court. (See Appendix B for a copy of this interview protocol).

Treatment Staff Surveys & Philosophical Orientation

Chapter 6 – Prior to visiting each site, treatment program administrators were contacted and asked to provide a list of staff who were directly involved in the delivery of services to drug court clients. The researchers then brought a survey packet for each of the previously identified staff members, during the site visit and delivered them in person to the counselors. The packet included the survey instrument (described below), a stamped envelope addressed to the researchers, and a consent form explaining the purpose of the

study, any anticipated risks and benefits for participating in the survey portion of the project (including the $25 stipend for returning the completed survey). Instructions in the packet directed the counselors to complete the survey and return it directly to the researchers via mail, in order to safeguard their responses.

The staff survey included items soliciting information on educational background, experience providing drug treatment services, credentials, average amount of time spent on several activities during a typical week (e.g., assessments, group counseling, etc), demographic information, program characteristics (e.g., client's expected length of stay in the program, use of a wait list, use of drug testing) and the provision of treatment adjuncts (aftercare drug treatment, medical services, legal aid, etc), among other types of data. (See Appendix C for a copy of the Treatment Staff Survey).

In addition to this programmatic and staff level data, counselors were asked to complete a Philosophy of Drug Abuse Causation and Treatment Survey (this instrument is also included in Appendix C). This instrument asked counselors to rate their level of agreement (using 5-point Likert scales, 1=strongly agree, 5= strongly disagree) with various statements about the causes of drug use. These items include questions such as "Most drug abusers have significant social skill deficits which lead to their drug abuse".

Counselors were also asked a similar set of questions regarding what they believed to be important aspects of effective drug treatment, such as "Effective drug abuse treatment includes a focus on social skill deficits common to drug abusers". Both the "causes of drug abuse" and "treatment of drug abuse" questions are organized into scales representing various criminological and psychological theories of drug abuse, including for example, conflict perspective, control theory, social learning theory, and psychoanalytic approaches. These data were sought in an attempt to uncover the relationship between what counselors think are important causes of drug abuse and the types of interventions they believe are effective.

Direct Treatment Observations

Chapter 7 – Prior to visiting the treatment programs associated with each of the courts, the research staff contacted each treatment provider in the jurisdiction and requested schedules of treatment activities for the week of the visit. These schedules were used to plan for the direct observation of various treatment services at each program. The number of programs involved in the provision of clinical services varied by court, from a single court-run treatment program at St. Mary Parish drug court, to a dozen or more potential providers at the Bakersfield site. As such, the researchers were forced in some sites to observe only those programs that served a large proportion of the court's clients. For example in Bakersfield, with several community-based providers working with the court, the researchers decided to observe meetings at the 5 programs serving the largest number of the drug court's clients. Limitations on the number of observational staff meant that not all meetings at all sites (even among this reduced number of programs at Bakersfield) could be observed. The researchers developed an observational schedule that maximized the number of meetings that could be observed during the 4-day time period spent at each site.

In some cases, the programs offered more meetings at a single, given time than could be observed with the number of raters available (for example, 3 meetings all taking place at 6pm, with only 2 observers available). Factors other than the limited number of observational staff also worked against observing every scheduled meeting during the site visit. For instance, some treatment programs (particularly in Bakersfield) failed to offer fully half of the meetings it was scheduled to provide. In this example, the cancelled meetings were the result of staff failing to show up for the groups they were scheduled to provide.

Despite these limitations on the total number of meetings that could possibly be observed, the researchers were able to attend a large proportion of all the meetings offered in these programs. While recognizing the potential limitations in the sample of observed meetings, given the exploratory nature of the evaluation, the proportion of meetings that were observed seems to have generated an adequate sample from which to draw some tentative conclusions and pose some important questions about the implementation of this type of program.

The observational technique used in this study is based on previous work by Taxman and Bouffard (2000) employing a similar structured observational technique in jail-based therapeutic community programs. The technique employed in the current evaluation was revised from its original version in order to improve its accuracy in quantifying the amount of time spent on various treatment activities. The current version of the observational protocol measures the amount of time spent on various treatment topics and activities by having trained observers record, in five-minute increments, the amount of time dedicated to these various treatment items, as they directly observe the activities. (See Appendix D for a copy of the observational instrument).

During each site visit, trained observers were assigned to observe treatment meetings at the various programs in the jurisdiction. Attempts were made, in jurisdictions with more than one provider, to have the same rater attend all the meetings at a single site, in order to facilitate the clients' becoming comfortable with being observed. Generally, observers sat unobtrusively in the treatment meetings and only interacted with clients or staff in introducing themselves during the initial meeting. Observers were also instructed to readily answer any questions that client's had regarding the purpose of their presence, but were told to refrain from further involvement in any treatment activities or discussions. Observers introduced themselves during their initial observation, explaining the purpose of the visit, the confidential nature of the data being gathered, and that any client who wished not to be observed was free to attend an alternate treatment activity with no penalty whatsoever. The researchers had reached agreements with each provider that any client wishing not to be observed would be allowed to switch meetings during the period of the site visit. No client in any program in any jurisdiction refused to participate in a meeting under observation. Clients had all been previously informed of the researchers' upcoming visit.

While the presence of an observer in the treatment meetings may be expected to decrease client (and possibly staff) openness, the observation of meetings over a period of several days allows the clients and staff time to become accustomed to the observer's presence and return to more typical behavior. In fact, the anecdotal impression of all the observers was that enough unflattering behavior occurred, relevant to both client and staff

conduct (e.g., clients sleeping in treatment, staff allowing them to sleep without confrontation) during the observations that the researchers were able to observe relatively normative examples of the treatment experiences provided in these programs.

Observers were trained in the use of the observational instrument prior to visiting each site. Training involved several meetings with the senior research staff and the graduate student observers to discuss the overall method and particularly the definitions of each observational item. In addition, senior research staff and the graduate student observers practiced using the instrument in actual drug abuse treatment activities in several local programs before the site visits occurred. Observers and senior research staff met to discuss their rating decisions after each of these practice observations, so that consensus was reached about the implementation of the definitions in realistic settings.

In an additional attempt to ensure the consistent application of the item definitions, observers met after each day's observations at the actual research sites, to discuss any ambiguities they might have encountered during those observations. Observers were instructed to write a detailed note describing any ambiguous treatment activity, which was then used in the post-observation meetings to describe that activity to the other observers. During these post-observation researcher meetings, the graduate student observers described any activities they felt might have been ambiguously coded and together with the senior research staff worked to reach a consensus on what item that activity represented. In this way, all ambiguous items were coded in a manner consistent with the intended definitions across observers. Items that did not fit the criteria for any of the pre-defined items were coded as "other" and the detailed notation about that activity was subsequently examined to create several new items (e.g., video-clients spent treatment time watching a video tape).

Given the nature of the observational method employed in this project, traditional measures of inter-item reliability, such as Cronbach's Alpha, are inappropriate, since the items being observed are not intended to represent parts of a unidimensional scale. As such, it is difficult to quantify the level of inter-item reliability for the measure. Inter-rater reliability is equally difficult to quantify using traditional statistical techniques, however comparisons of observer's ratings taken from two of the practice observations indicate that the level of agreement was relatively high.

In addition, the original observation technique developed by Taxman and Bouffard (2000) showed relatively good indications of inter-rater reliability, even without using the improved method for quantifying the amount of time spent on each item. Improvements in the measurement of time devoted to each treatment item likely serve to improve the consistency of this type of observational technique, given that the operational definitions of each item are similar to those employed in the original method.

Within this observational method raters were allowed to code more than one item as occurring simultaneously. For example, in a hypothetical case a treatment group may have discussed "Existing Cognitive Processes" for 60 minutes and "Family Issues" during 15 minutes of that overall 60-minute discussion. In this case, the observational data would suggest a total of 75 minutes worth of activity occurred, within a 60-minute period. However, the intent of these observations is to ascertain the amount of time that the group spent on each of several types of topic or activity, relative to the overall length of the

meeting. In other words, the observational data is a means to cataloging the emphasis of these programs in terms of their overall approach to treatment (i.e., cognitive-behavioral, 12-steps, psychoanalytic, etc). To this end, rather global measures of the types of activities and topics provided were sought, rather than outlining in specific detail the exact nature of each topic.

The fact that some topics/activities may be multiply classified does not detract from the fact that for 15 minutes the group did discuss "Family Issues" and also spent 60 minutes discussing "Existing Cognitive Processes" more generally. In terms of the overall goal of the project, this set of results would suggest that at least in this meeting the program appears to be cognitive-behavioral in its approach. If this pattern of results was repeated in many of the treatment meetings offered by this program, we could then reasonably conclude that the program is cognitive-behavioral in its overall treatment approach.

In line with this goal and for simplicity's sake, results will be presented in terms of each item separately, with no attempts being made in this exploratory study to examine the prevalence of specific, combined topics or activities (e.g., existing cognitive processes related to family issues). While these issues may indeed be of importance to understanding, at a more complex level, the intricacies of drug treatment within the drug court context, those sorts of questions are somewhat beyond the scope of this initial evaluation, which merely attempts to describe the overall approach, implementation and integration of these treatment programs within the drug court structure.

Drug Court Staff Interviews

Chapter 3 – Prior to visiting each site, members of the drug court staff were contacted for an interview during the week of the visit. A total of twenty interviews were conducted with drug court personnel, including judges, prosecutors, defenders, and case managers. The purpose of these forty-minute interviews was to obtain descriptive information about the drug court. Additionally, drug court staff were asked open-ended questions about the relationship between substance abuse and crime, and the role substance abuse treatment played in the drug court setting. (See Appendix E for a copy of this interview schedule.)

In addition, a separate interview was conducted at each site with the person responsible for case management regarding the availability of treatment services. During the initial fieldwork phase of the study, OJP released Treatment Services in Adult Drug Courts: Report on the 1999 National Drug Court Study by Elizabeth Peyton and Robert Gossweiler, 2001. The research team incorporated the TASC survey into the research study by conducting an interview with staff at each site using the questionnaire. This instrument supplements other interviews conducted for this project.

Retrospective Analysis of Participant Data

Chapters 3, 8, & 9 – The retrospective portion of the evaluation consists of an analysis of 2357 participants who were enrolled in drug court (enrolled one or more days

between January 1st 1997 and December 31st 2000), were either terminated or graduated, for whom both a minimum amount of follow-up time (12 months) had elapsed since graduation or discharge, and for whom NCIC criminal history information was available.

Table 2.1 documents the specific manner in which the sample was constructed. Initially, information on a total of 4003 drug court participants was obtained over the four-year period (January 1st 1997 and December 31st 2000). Of these, 366 participants were excluded from the study as they were still active at the time fieldwork was conducted. An additional 617 participants who were assessed but were not admitted into the drug court were also excluded (referred to as administrative opt-outs). Of the remaining 3,020 drug court participants, 385 participants were not matched with NCIC records and of those that were matched with NCIC, an additional 278 participants were excluded given that less than 12 months time had elapsed from their date of discharge.

Table 2.1 Sample Construction

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Totals*
Total 48 month enrollments 1997-2000	551	402	1054	1996	4003
Total Cases Still active at time of data collection	109	65	127	65	366
Number of Administrative Opt Outs	74	16	134	393	617
Total Terminates and Graduates	368	321	793	1538	3020
Terminates and Graduates Matched With NCIC	220	312	727	1376	2635
Matched NCIC Graduates and Terminates Discharged for 12 Months	0	120	4	154	278
Total Cases With Scheduled Data Time	220	192	723	1222	2357

Sources of Participant Data

Information on drug court participants existed in a number of mediums and formats, the content of which varied considerably both within and across sites.

St. Mary Parish: Demographic information on drug court participants was obtained from a database that is maintained by staff at the Fairview Treatment Center. The data consists of elements associated with the Addiction Severity Index (administered to all participants at intake and graduates upon discharge). Participant case files maintained on hard-copy form were reviewed to collect treatment attendance records, drug test results and verification of discharge information.

Creek County: Participant level data from Creek County was obtained manually from a review of participant case files maintained on hard copy by staff at CBTI. The research team devised a data collection instrument and a staff member from CBTI manually completed the form for each drug court participant.

Bakersfield: Data was obtained from a Microsoft Access database specifically designed for the drug court. Staff from the Kern County Department of Mental Health maintains the

database that includes participant demographics, treatment attendance records, progress notes and drug testing information.

Jackson County: Information on participants at the Jackson County drug court was maintained in a variety of locations. Some data was obtained from the High Intensity Drug Trafficking System Automated Treatment Tracking System (HATTS) which includes the Addiction Severity Index (ASI), treatment services information, drug testing, sanction information, and AA/NA attendance. Demographic and discharge information on drug court participants was obtained from multiple sources including HATTS, a prosecutorial database, spreadsheets maintained by the Drug Court Coordinator and manually from hard copy forms. Treatment attendance and drug testing information was obtained from both HATTS and spreadsheets maintained by the treatment provider.

Data Elements Collected

Cross-site participant data includes general demographics, treatment attendance, outcomes of drug and alcohol testing, and program termination status. The types of data elements stored electronically and the manner in which it was stored varied considerably across sites. As a result, some data elements collected were not included in the final analysis. Table 2.2 summarizes the percent of primary cross-site data elements included in the final study. Table 2.2 does not list secondary elements constructed (i.e.: age constructed from date of birth and date of admission) nor NCIC criminal history information obtained independently from the Justice Department.

Program information collected on participants includes drug court program start and end dates, frequency of treatment sessions attended, number of drug tests administered and corresponding results. As shown in Table 2.2, the majority of missing drug test and treatment attendance information is attributable to both the Bakersfield and Jackson County drug court sites. In Bakersfield, a new management information system was introduced in the 1999-2000 year period and drug testing and treatment attendance information on out-dated participants was not updated. Similarly, the Jackson County drug court also introduced a new management information system in 2000-2001, however, during this time period, the research was able to recover some drug testing information that was located in a separate excel spreadsheet maintained by the Treatment provider.

The research would have benefited from the collection of other types of program information that was either unavailable, or impossible to collect given the amount of time allocated for each site visit. Specifically, types and frequency of sanctions and reasons for discharge were not routinely maintained by any of the sites across the study time period. Obtaining start and end dates for treatment proved problematic as well. This information typically existed on hard-copy form and maintained by the treatment provider. In the case of the Bakersfield site, for example, the drug court program maintained this information but the data elements did not differentiate between date of assessment and actual start of treatment. In the case of Jackson County, treatment start and end dates were available from the treatment provider but impossible to collect since collection required a review of hard-copy records for over 2,000 participants.

Frequency and types of demographic information on participants also varied across sites. The St. Mary Parish Drug Court maintained the most information on participant characteristics collecting ASI (Addiction Severity Index – Long Version) in automated form. Treatment providers at both the Jackson County and Bakersfield sites also used the ASI, however, the drug court program in their Management Information System maintained only certain variables from the ASI. And, in the case of the Creek County Drug Court, participant characteristics consistent with the ASI were derived from a hard-copy bio-psychosocial assessment independently developed by the treatment provider and collected manually by the research team at the time of the site visit.

Table 2.2 Primary Data Elements Collected

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
	N=220	N=192	N=723	N=1222	N=2357
Program Information					
Drug Court Program Start Date	100	100	100	100	100
Drug Court Program End Date	100	100	100	100	100
Number of Treatment Sessions Attended	97.3	97.9	61.5	30.2	51.6
Number of Drug Tests Administered	99.1	91.7	66.0	87.1	82.1
Number of Positive Drug Tests	99.1	91.7	66.0	87.1	82.1
Participant Characteristics					
Date of Birth	100	100	100	100	100
Gender	100	98.4	99.9	100	99.8
Race/Ethnicity	100	100	100	99.9	100
Last Grade Completed	100	100	67.1	30.5	53.9
Employment Status at Admission	100	100	100	38.5	68.1
Marital Status	100	99.5	100	37.4	67.5
Number of Financial Dependents	100	100	35.5	36.1	47.1
Received Prior Substance Abuse Tx	100	100	100	29.1	63.2
Substance Use Histories					
Age at First Use	100	100	64.2	33.3	54.4
Type of Substance First Used	100	100	64.2	33.1	54.3
Ever Used Alcohol	100	100	100	39.5	68.6
Used Alcohol Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Alcohol	100	100	100	39.5	68.6
Ever Used Marijuana	100	100	100	39.5	68.6
Used Marijuana Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Marijuana	100	100	100	39.5	68.6
Ever Used Crack/Cocaine	100	100	100	39.5	68.6
Used Crack/Cocaine Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Crack/Cocaine	100	100	100	39.5	68.6
Ever Used Amphetamines	100	100	100	39.5	68.6
Used Amphetamines Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Amphetamines	100	100	100	39.5	68.6
Ever Used Opiates	100	100	100	39.5	68.6
Used Opiates Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Opiates	100	100	100	39.5	68.6
Ever Used Other Substances	100	100	100	39.5	68.6
Used Other Substances Last 30 days	100	100	100	39.5	68.6
Length of Time Use of Other Substances	100	100	100	39.5	68.6

NCIC Data Elements

Table 2.3 summarizes information collected on participant arrest histories obtained from the National Crime Information Center (NCIC). Primary data elements include: date

of first arrest, frequency and general types of prior arrests, initiating offense upon drug court admission as well as types and corresponding dates of subsequent post-admission drug court arrests.

Table 2.3 NCIC Primary Data Elements

NCIC Prior Arrest Information	*NCIC Post-Admission Arrest Information*
Date of First Arrest	Date of 1st Arrest post-Admission DC
First Arrest Charge	1st Arrest Charge post-Admission DC
Number of Prior Arrests	Date of 2nd Arrest post-Admission DC
Number of Prior Personal Arrests	2nd Arrest Charge post-Admission DC
Number of Prior Property Arrests	Date of 3rd Arrest post-Admission DC
Number of Prior Drug Arrests	3rd Arrest Charge post-Admission DC
Number of Prior Motor Vehicle Arrests	Date of 4th Arrest post-Admission DC
Number of Prior Arrests (Other)	4th Arrest Charge post-Admission DC
Drug Court Charge	Date of 5th Arrest post-Admission DC
	5th Arrest Charge post-Admission DC
	Date of Last Arrest
	Last Arrest Charge
	Most Serious Charge post-Admission DC
	Number of Arrests post-Admission DC

Regression Analyses

Chapters 8 & 9 – Step-wise regression methods are employed in chapters 8 and 9. These analyses provide information about compliance in drug court, the factors contributing to the likelihood of graduation/discharge, and the extent these combined measures relate to post-program recidivism. Each of the multivariate models complement the accompanying bivariate analyses presented in each chapter by assessing the salience of each factor among control variables. Separate models are estimated for each site as variations in missing cases prohibit the inclusion of all variables at all four sites. The high degree of collinearity among many of the independent variables necessitates the use of the stepwise method.

In chapter 8, regression models test the combined effect of participant characteristics and program compliance measures on graduation. Since drug court graduation is largely a function of compliance with drug court protocols, the relationship will be explicitly tested in the models in order to ascertain which aspects of compliance are most critical. Those background variables remaining significant in the models amidst program compliance play a crucial, independent role. Successful completion of the drug court program (or graduation) serves as the dependent variable of interest. Graduation is coded "1" and program termination is coded "0." The logistic regression models predict the odds of graduation versus termination at each of the four sites. Three compliance indicators include positive drug tests, in-program arrests, and treatment attendance.

In chapter 9, the relationships among participant characteristics, measures of program compliance, discharge status, and time at risk (exposure) are tested on the

likelihood of recidivism at each of the four sites. Post-program arrest serves as the dependent variable of interest. Those not arrested are coded "0" and those who were arrested one or more times after program participation are coded "1." The logistic regression models predict the odds of arrest versus no arrest at each site. The independent variables pertaining to participant characteristics are divided into general demographics, prior substance use and arrest histories and program compliance measures.

Demographics: Gender is dummy coded (females = 1). After exploratory analysis of each racial category, no variation within race was found. Therefore, race is also dummy coded (nonwhites = 1). Given its non-normal distribution and the possibility of non-linear effects, participants' age is recoded into four categories. The "Less than 20 years" category is omitted as the baseline. Three other categories ("20 to 29 years," "30 to 39 years," and "40 or more years") are analyzed against the reference group. The participants' number of financial dependents is dummy coded (one or more dependents=1). Education is dummy coded with "not a high school graduate" serving as the baseline (high school graduate or greater=1). Employment status at time of admission is also included. Those participants who held a job at the time at which they entered the program are coded "1." The last variable included in the model, marital status, was also dummy coded (not married = 0).

Substance Use and Arrest Histories*:* Prior use of alcohol, marijuana, crack/cocaine, methamphetamine, opiates, and other substances are each dummy coded (ever used=1). Prior substance abuse treatment is also included. Those participants who had ever received prior substance abuse treatment at the time at which they entered the program are coded "1". Participants' prior arrest was coded as a categorical variable and then dummy coded. The "no prior arrest" category is omitted as the baseline. Two other categories ("one or two arrests" and "three or more arrests") are analyzed against the reference group. The age of the participant at the time of their first arrest is also included in the model. To improve the skewness of this measure, the variable was transformed with the natural logarithm. The last variable included in this model represents the participants' age at first use. This continuous variable is normally distributed.

Compliance Measures: The compliance measure taps those participants who had one or more arrests during their participation in the drug court program. This measure is dummy coded (those having one or more arrests = 1). The next set of compliance indicators represents participant compliance in relation to positive urinalysis. Approximately 24% of the sample had no positive tests. The remaining 76% of participants were coded into three separate categories of roughly equal size, creating a quartile measure. Dummy variables were constructed from these quartiles. The "no percent positive test" category is omitted as the baseline. The three other categories (".01 to .08 percent positive," ".09 to .28 percent positive," and ".29 to 1.0 percent positive") are each analyzed against the reference group. The final compliance measure, treatment attendance, is computed as a percentage reflecting the actual number of treatment sessions attended over the theoretical minimum number of sessions expected to attend. The treatment attendance measure ranges from 0 to 283%. It approximates a normal distribution and is employed in the model as a continuous variable.

Chapter 3

Comparison of the Four Drug Court Programs: Court Personnel Perspectives on Drug Court

Overview

This chapter provides information about the four drug courts and how participants are processed through drug court programs. The goal of the chapter is to provide both a descriptive account of how the programs are organized and compare key operational components of the four drug courts, including program structure, eligibility, target populations, and drug testing protocols.

Information for this chapter was obtained from two primary data sources: (1) Policy level information was obtained from client handbooks, policy and procedure manuals and interviews with drug court personnel; (2) Information about participants was obtained from treatment and drug court records as well as the NCIC. Detailed descriptions of these data sources can be found in Chapter 2.

The chapter is organized as follows: The first section provides a brief overview of each drug court program under study. The second section provides cross-site comparisons of structural and operational aspects of each program.

Overview of Each Jurisdiction

As described in Chapter 2, this research examined drug court operations in four mentor courts. As documented below, the four jurisdictions include a program that is a single-site court with multiple treatment providers (Bakersfield, California), a multi-site drug court with a single treatment component (Jackson County, Missouri) and two single-site drug courts with one treatment component (Creek County, Oklahoma and St. Mary Parish, Louisiana). Site selection includes drug courts from two rural communities (Creek County, Oklahoma and the St. Mary Parish, Louisiana) and two urban areas (Bakersfield, California and Jackson County, Missouri).

St. Mary Parish, Louisiana

The St. Mary Parish drug court, located in the 16th Judicial District in Franklin, Louisiana (pop. 5,000), is the first drug court jurisdiction. The parish is 63% white, 32% African American 1% Native American, and 4 % other. Offshore oil and gas, fishing and sugar cane industries dominate the local economy. The cities of New Orleans and La Fayette are within an hour's drive of the parish courthouse. The Office of Justice

Programs reports that since implementation in 1997, the St. Mary Parish Drug Court has served 577 participants of which 133 have graduated from the program[1].

The St. Mary Parish drug court has a single treatment agency providing direct services to drug court participants. It is a post-plea, post adjudication program that meets weekly. With a capacity for 200 participants at any one time, the drug court program consists of four phases designed to take from nine to sixteen months to complete.

The drug court team consists of the judge, treatment provider and counselors, sheriff, compliance monitor, probation officer, public defender and prosecutor. Both case management and treatment services are provided by the Fairview Treatment Center, which is also the dedicated provider serving other drug courts in the 16th Judicial district. The Fairview Treatment Center provides detoxification, residential, in-patient, and outpatient treatment services. Through various arrangements with other organizations, the program also provides a range of ancillary services.

The District Attorney's Office has its own probation officer who determines legal eligibility. Eligible defendants are clinically screened and assessed by the direct treatment provider and the entire drug court team recommends placement in the program. The defendant executes a post-bail conviction contract and enters a two-week orientation phase of the program during which they may voluntarily opt out. According to interviews with drug court personnel, the entire process from initial identification of the client to admission to the drug court takes less than two weeks.

Creek County, Oklahoma

The second jurisdiction is located in Sapulpa, Oklahoma (pop. 19,166), the seat of Creek County District Court. The local economy consists of agriculture and small manufacturing. Creek County (pop. 63,370) is a primarily rural area that is evolving into a suburb of Tulsa and Oklahoma City. The population is 82% white, 3% African American, 9% Native American and 6% other. The Office of Justice Programs reports that since implementation in 1997, the Creek County Drug Court has served 673 participants of which 169 have graduated[2].

The Creek County Drug Court contracts with a single treatment agency providing direct services to participants. It is a post-plea, post-adjudication program enrolling up to 150 participants at any one time and meets on a bi-weekly schedule.

This program is unique in having two separate drug court dockets - a misdemeanor and felony docket. Most misdemeanant defendants are placed in a modified treatment program consisting of one of three treatment tracks lasting 3-months, 6-months, or 9-months respectively. Felony defendants are typically placed in the full

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[1] OJP Drug Court Clearinghouse and Technical Assistance Project. "Drug Court Activity Update: Summary Information on All Programs and Detailed information on Adult Drug Courts. June 20, 2001.

[1] OJP Drug Court Clearinghouse and Technical Assistance Project. "Drug Court Activity Update: Summary Information on All Programs and Detailed information on Adult Drug Courts. June 20, 2001.

drug court program requiring four phases of treatment that is at least twelve months in duration. Operated by the prosecutors office, the drug court team consists of the drug court judge, the district attorney and assistant, the state's Community Sentencing Board's probation officers, the Creek County Clerk of Courts, two public defenders and the dedicated treatment provider.

The district attorney conducts a legal screening to determine initial eligibility of defendants. The legal screening considers the defendant's current charges and prior convictions and makes a qualitative assessment as to the offenders' level of involvement with alcohol and/or drugs. Potential drug court participants who satisfy legal screening requirements are referred to the dedicated provider where a clinical assessment is conducted. Results of the clinical assessment serve as the basis for determining entry into the program, as well as initial placement decisions. The entire process is estimated by court personnel to take less than three weeks to complete.

Bakersfield, California

The Bakersfield Municipal Court serving Kern County (pop. 659,000), California is the third drug court jurisdiction in the study. It is one of three adult drug courts in Kern County serving a population of 386,000 people. The metropolitan area is 66% white, 21% Hispanic, 9% African American and 4% other. The Office of Justice Programs reports that since implementation in 1993, the Bakersfield Municipal Drug Court has served 2660 participants of which 666 have graduated.[3]

The Bakersfield Municipal Drug Court is a post-plea, post adjudication program with a capacity for 350 clients at any one time. It is a misdemeanant only drug court that consists of four phases and is designed to take approximately twelve months to complete. The Bakersfield Municipal Drug Court has seven (7) primary treatment agencies providing substance abuse treatment services to drug court participants. The drug court meets four times a week in the afternoon. Two substance abuse specialists from Bakersfield Department of Mental Health serve as case managers for the drug court. The drug court team also includes the judge, drug court coordinator, probation officer, the district attorney, representatives from the treatment community, and data entry personnel.

To enter the drug court, defendants are legally screened by the Department of Probation. The legal screening considers the defendant's current charges and prior convictions and makes a qualitative assessment as to the offenders' level of involvement with alcohol and/or drugs. Potential clients meeting the program's legal screening requirements are referred to one of the two Substance Abuse Specialists who conduct a clinical screening. Suitable candidates are offered a drug court contract and, once executed, are assigned to a treatment provider in the geographical proximity of their residence where a clinical assessment is conducted. According to drug court personnel, the process from identification to admission takes approximately two to three weeks to complete.

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[3] OJP Drug Court Clearinghouse and Technical Assistance Project. "Drug Court Activity Update: Summary Information on All Programs and Detailed information on Adult Drug Courts. June 20, 2001.

Jackson County, Missouri

The fourth jurisdiction is the Jackson County Circuit Court located in Kansas City and Independence, Missouri. With a population of 654,880, Jackson County is one of the most densely populated counties in the State of Missouri. The county is 70% white, 23% African American, 1.5% Asian, 0.5% Native American and 5% Other. The drug court is a multi-site program serving both Kansas City (pop. 443,400) and Independence, Missouri (pop. 116,000). The Office of Justice Programs reports that since implementation in 1993, the Jackson County Drug Court has served 3765 participants of which 1717 have graduated[4].

The Jackson County COMBAT Drug Court Diversion program contracts with a single treatment agency. Unlike the other three drug courts, this is a deferred prosecution diversion drug court program. The drug court has a capacity for 400 participants and meets four times a week. The program targets first-time and second-time non-violent drug involved offenders. According to drug court personnel, the program is designed to take a minimum of twelve months to complete. Participants are required to complete three phases of the program that includes specific court and treatment requirements.

The drug court team consists of the drug court prosecutor, case manager, the Drug Court Commissioner, public defender (District Defender), diversion managers (Missouri Pretrial Release Officers - probation officers), the treatment provider, a client advocate and data entry personnel. The Drug Court Commissioner is appointed by an elected judiciary and serves as a drug court judge. Case management services are provided through the prosecutor's office that is also responsible for overseeing the program.

With the exception of residential treatment, drug court participants receive substance abuse treatment services from the sole dedicated treatment agency, County Court Services. Serving the drug court since 1995, County Court Services is responsible for all clinical assessments and treatment placements. Participants are placed in one of six levels of care, four of which are monitored by County Court Services who provides three of these levels of care: outpatient, intensive outpatient, and a therapeutic community at a day treatment center. They also determine when residential placements are appropriate.

Case managers conduct legal screenings on all drug-involved arrestees referred to the drug court prosecutor by law enforcement. At their initial appearance, eligible defendants are offered the opportunity to participate in the drug court program. When a defendant chooses to participate, they are assigned one of the eight Diversion Managers (probation officers). Then they are sent to County Court Services where defendants are clinically assessed and assigned to an appropriate level of care. After a treatment level has been assigned, the defendant makes a second appearance before the Commissioner, executes the Drug Court Diversion Contract, and enters the first phase of treatment. Staff

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[4] OJP Drug Court Clearinghouse and Technical Assistance Project. "Drug Court Activity Update: Summary Information on All Programs and Detailed information on Adult Drug Courts. June 20, 2001.

members indicate that the process from initial identification to admission to the drug court takes approximately three weeks.

Cross-Jurisdictional Comparisons of Drug Court Operations

This section examines structural characteristics of the four drug court program. Concern lies with comparing key ingredients of the four programs. Table 3.1 presents cross-site comparisons of structural characteristics of the four drug courts as reported by drug court personnel and described in policy and procedure manuals. It presents information on program operations, number of levels or tracts and the number of program phases. The first row compares the drug court program structures.

There are differences among the four programs in the types of drug court structures affecting the selection and processing of cases. Three drug courts are post-plea, post-adjudication programs while the Jackson County drug court is a pre-plea, drug court diversion program. There are also differences in target populations. While all four programs comport with federal requirements excluding violent offenders, the selection of target populations differ by site. The two rural drug courts target both felony and misdemeanor offenders. The two urban drug courts are different. The Jackson County drug court targets only first-time offenders and the Bakersfield program only targets offenders with misdemeanor and OUI/DWI charges.

Like most drug courts in the United States, the St. Mary Parish and Bakersfield programs have a single track for processing cases (Table 3.1 row 2). However, the Creek County and the Jackson County drug courts have multiple tracks or levels of care. At the Creek County site, substance involved defendants with minor criminal charges (e.g. OUI/DWI) are placed in one of three "modified" tracks of three, six, or nine months in duration. Participants with more serious offenses are placed in the regular twelve-month track. Various levels of care are provided participants at the Jackson County site depending on the severity of their addiction problem. However, participants at all levels of care at this site are expected to participate in the program for twelve months. What varies is the intensity of treatment they receive – residential treatment, day treatment, or intensive outpatient. And, offenders with less serious substance problems are assigned to outpatient programs.

Table 3.1 also presents cross-site comparisons of program phasing. All four programs offer a step-down phased system of requirements meaning that as participants progress through program phases, both treatment and court requirements decrease. While step-down requirements vary by site, they are similar insofar as phases include attendance requirements at treatment sessions, drug court status hearings, and drug testing. Two sites have a four-phase program and two have a three phase program.

Interviews with court personnel suggest that the drug court phases described in Table 3.1 are used as by court personnel and participants as benchmarks to determine progress towards program completion and graduation. In Chapter 4, we will discuss whether differentials could be discerned in how participants were processed during treatment sessions we observed.

Table 3.1 Cross-Site Comparisons of Drug Court Structure, Operations and Phases

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Drug Court Structure	Post-plea, post adjudication	Post-plea, post adjudication	Post-plea, post adjudication	Pre-plea, pre-adjudication
Differentiated Program Levels or Tracks[5]	One	2 drug court tracks 4 treatment tracks	One	Six treatment tracks
Phase I	2 months	3 months	4 months	4 months
Phase II	4 months	3 months	4 months	4 months
Phase III	3 months	3 months	4 months	4 months
Phase IV	6 months	3 months	NA	NA
Program Length[6]	15 months	12 months	12 months	12 months
Date of Inception	1997	1997	1993	1993
Target Population	First time felony and misdemeanants	First time felony and misdemeanants	DUI/DWI and misdemeanant Offenders only	First time felony and misdemeanants

Processing Offenders

One of the critical issues for drug courts is the selection of potential participants from the target population. Program eligibility (described in Table 3.1) establishes the universe of offenders from which court and treatment personnel select potential drug court participants. The initial determination or selection of specific clients occurs on the basis of a legal screening, which is conducted by court personnel. Drug court personnel report they select offenders on the basis of legal criteria who are then subsequently screened by treatment providers who assess the nature and extent of their substance abuse problems.

Information in Table 3.2 consists of cross-site comparisons of court personnel perspectives on the intake process at each jurisdiction. It indicates how participants are processed into the drug court and by whom. As shown in Table 3.2, either the prosecutor's office or probation officers conduct the legal screenings. No standardized risk screeners were employed by any of the four courts.

Potential participants who meet legal eligibility requirements are referred to treatment providers who conduct clinical screenings and assessments. With the exception of the Bakersfield drug court, the drug courts are similar with respect to designating treatment staff to conduct clinical screenings and assessments. In addition to an interview with the potential participant, three of the four drug courts use the ASI as a clinical screening and assessment tool. The Creek County drug court uses the SASSI, LPQ, and Mortimer instruments. (For a more thorough discussion of this issue from treatment personnel perspectives see Chapter 5 below.)

[5] Does not include participants placed in residential treatment
[6] Program and phase lengths reflect minimum time frames for completion.

Table 3.2 Intake: Legal and Clinical Screenings and Clinical Assessments

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Legal Screening	Probation from DA Office	District Attorney	Probation	District Attorney
Legal Screening Tool	Non-standardized	Non-standardized	Non-standardized	Non-standardized
Clinical Screening	Treatment Provider	Treatment Provider	County Dept. of Mental Health	Treatment Provider
Screening Instrument	ASI	SASSI, LPQ, Mortimer	Self-Developed Non-standardized	ASI
Clinical Assessment	Treatment Provider	Treatment Provider	Treatment Provider	Treatment Provider
Clinical Assessment Instrument	ASI and Interview	Self-Developed Bio-Psychosocial and Interview	ASI and Interview	ASI and Interview
Mental Health Assessment	Treatment Provider	Referred	Treatment Provider	Treatment provider
Case management	Treatment Provider	Treatment Provider	County Dept. of Mental Health	District Attorney's Office

An important issue regarding the intake process is the length of time between the identification of potential participants and admission to the program – that is, how long it takes participants to be admitted to the program. Table 3.3 summarizes interviews and official policy and procedure manuals as to the amount of time involved between initial identification of participants and program admission. Overall, court personnel at each site report the entire screening and assessment process - the length of time it takes between referral and admission into treatment – is typically completed within three weeks. Unfortunately, participant level data was not available to assess the amount of time it actually takes to be admitted into these drug court programs.

Table 3.3 Court Personnel Perceptions of Time Between Identification of Clients and Admission

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Time between initial identification to completion of clinical screening	1 –2 days	More than two weeks	3-5 days	1Week
Time between initial identification to completion of assessment	1 week	1-2 days	3-5 days	1week
Time between determination of clinical eligibility and admission to treatment	Same day	1-2 days	1-2weeks	1 week
Time period between initial identification and admission to drug court	2 weeks	3 weeks	2 to 3 weeks	3 weeks

Table 3.4 presents cross-site comparisons of actual criminal history profiles of participants obtained from NCIC files. The first column shows the number of arrests prior to entering the drug court program (excluding the admission offense). This is followed by the type of offenses. The final column examines the type of arrest offense immediately preceding participant admission into the drug court program.

Actual criminal history profiles are largely consistent with characteristics of the target population described in Table 3.1. Overall, NCIC data indicate that 82.1% of the drug court participants have one or more prior arrests. There are cross-site variations in the number of reported prior arrests. In particular, drug court participants at the Creek County and Jackson County sites have fewer reported arrests than other sites reflecting differences in their target populations.

It will be recalled from Table 3.1 that Jackson County is a program for first and second time offenders. As shown in table 3.4, over eighty-five percent of participants at that site have fewer than two prior arrests. At the Creek County drug court, the distribution of the number of prior arrests is, as expected, bimodal, matching their multiple track programs for offenders. Overall, the majority of arrests (75%) immediately preceding admission to the program were drug related.

Table 3.5 examines information about participant's actual drug usage in terms of the past 30 days and lifetime use. Those findings indicate drug court participants are polysubstance abusers. At each site, more than half of the participants report lifetime use of alcohol and marijuana as well as other drugs. At each site more than half of the participants also report the use of other drugs including: crack/cocaine, opiates, and amphetamines. Past thirty day use and lifetime use are fairly consistent across sites.

Table 3.4 Cross-Site Comparisons of Actual Participant Level Criminal History Profiles

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Number of Prior Arrests					
None	10.9	34.9	8.6	22.1	17.9
One	23.2	20.8	14.7	28.5	23.1
Two or More	65.9	44.3	76.7	49.4	59.0
Types of Prior Arrests					
Personal	13.0	7.6	13.2	9.3	10.9
Property	29.5	19.2	23.0	27.0	25.4
Motor Vehicle/DWI	5.2	28.7	3.1	2.4	4.6
Drug	38.8	37.9	50.3	54.2	50.2
Other	13.6	6.8	9.6	6.3	8.2
Drug Court Arrest					
Personal	6.4	2.1	8.9	2.3	4.7
Property	22.3	7.3	9.3	9.7	10.6
Motor Vehicle	0.5	1.6	2.4	0.1	0.9
Drug	63.2	53.1	67.4	85.8	75.4
DUI/DWI	4.1	34.4	7.5	0.8	5.9
Other	3.6	1.6	4.7	1.2	2.5
Drug Court Arrest					
Felony	65.2	63.5	-	96.8	59.7
Misdemeanor	34.8	36.5	100	3.2	40.3

Table 3.5 Cross-Site Comparisons of Participant Level Substance Use Profiles

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*	*Total*
Ever Used (Lifetime)					
Alcohol	95.9	89.1	68.7	89.9	81.3
Marijuana	93.2	100	59.5	88.5	78.0
Crack/Cocaine	81.8	29.2	30.2	58.8	45.8
Amphetamines	5.0	58.9	67.5	23.9	45.3
Opiates	22.3	7.3	18.5	1.7	13.1
Other	38.2	24.0	10.4	16.6	17.7
Use Last 30 Days					
Alcohol	44.1	22.7	55.0	66.0	53.1
Marijuana	40.5	98.9	45.4	65.4	56.7
Crack/Cocaine	35.0	27.6	20.7	31.0	26.5
Amphetamines	0.0	14.1	51.3	7.2	27.2
Opiates	13.2	0.5	11.5	0.5	7.4
Other	6.4	6.8	9.0	3.1	6.7

Sanctions and Rewards

It will be recalled from Chapter 2 that participant level sanction and reward information was not available at any of the sites. However, interviews with drug court personnel indicate that each program routinely employs sanctions and rewards during status hearings. Sanctions and rewards are given to ensure participant compliance with program goals and objectives. Court personnel report that rewards are used to acknowledge participant progress. Typical rewards range from applause, verbal praise and various gift certificates to reductions in treatment sessions and drug testing, phase advancement and graduation. Unique rewards include tailored post cards sent by the Bakersfield judge to drug court participants.

Sanctions are imposed in response to positive urinalysis, new criminal charges, failure to attend scheduled counseling sessions and drug court hearings. Interviews indicate that typical sanctions include termination, docket placement, jail time, community service, curfews, increased treatment and drug testing. Unique sanctions include the "Rosemary Special" and the "Focus Sanction". The "Rosemary Special" sanction was developed at the Bakersfield site. Named after a client who ultimately graduated, this innovative sanction consists of required daily attendance at meetings of Alcoholics Anonymous and drug court hearings over a two-week time frame. It serves as a final warning to clients who are not in compliance with the program.

The Jackson County Drug Court developed an intervention sanction referred to as the "Focus Sanction" for participants experiencing difficulty maintaining an acceptable level of compliance with the program. It consists of the requirement to attend forty-eight hours of intensive treatment at the residential treatment facility and is intended to provide participants a second chance in the program. Participants who continue to experience compliance difficulties are reportedly terminated from the program.

Drug Testing Protocols

Drug testing is the fifth *Key Component* of drug courts: *"Abstinence is monitored by frequent alcohol and other drug testing."* The frequent use of drug testing in the drug court model is based on the assumption that close monitoring and sanctions for continued drug use will bring about reductions in drug use and, hence, crime. Although drug testing is a common requirement for participants at each drug court, there are cross-site differences in the drug testing protocol.

As shown in Table 3.6, a randomized drug testing protocol is in place at the Bakersfield and St. Mary Parish drug court programs. Contracts with two separate drug testing services at the Bakersfield site require clients to phone calls for the date and time of their tests. The treatment provider at the St. Mary Parish drug court conducts random drug tests using a color-coded system. According to drug court personnel, drug testing at the Jackson County and Creek County drug courts are not conducted on a random basis. Drug tests are reported to be administered by the treatment provider prior to treatment sessions. Drug tests at these sites are random only insofar as clients do not know whether they will be tested on the day of their scheduled treatment or court session.

There are cross-site variations in the drug testing protocol regarding the frequency of drug testing. The treatment provider reported that clients are typically drug tested once a week at the Creek County drug court. Drug testing at other sites is reportedly more frequently and varies by phase. For example, at the Bakersfield site drug testing is reported by court personnel to be as frequent as 10 times a month for Phase I participants.

On the basis of interviews with court personnel and an examination of the drug testing protocol, we calculated the minimum number of drug tests that would be required of participants who completed the program through graduation. This information is presented in Row 8 of Table 3.6. There are cross-site variations in this estimated minimum number of required drug tests ranging from 42 tests at the Creek County drug court to 64 tests for participants completing the program at St. Mary Parish. Chapter 8 compares these drug-testing protocols with actual drug testing practices at each site.

Table 3.6 Drug Testing Protocol

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Program Length	15 months	12 months	12 months	12 months
Randomness	Yes	No	Yes	No
By Whom	Treatment provider	Treatment provider	External Testing	Treatment
Type	Urinalysis/Swab/ Blow	Urinalysis/Blow	Urinalysis/Blow	Urinalysis Only
Phase 1	2x week 2 months	2x week 3 months	2x week 4 months	2x week 4 months
Phase II	2x week 4 months	1x week 3 months	1x week 4 months	1x week 4 months
Phase III	1x week 3 months	.5x week 3 months	1x week 4 months	1x week 4 months
Phase IV	.25x week 6 months	Unspecified 3 months	-	-
Expected Minimum Number of Drug Tests	66	42	64	64

Summary

Findings in this chapter suggest that the four drug courts are fairly diverse having their own distinct program characteristics. At the policy level, what are considered to be some of the most important characteristics of drug courts – determination of eligibility, drug testing, and graduated sanctions - are highly variable across sites. Although all programs have structured drug court phases, there are cross-site differences in this protocol - such as differences in the number and length of phases. In fact, one drug court reports using a modified program for less serious offenders with only ninety days allotted for the delivery of treatment services. There are drug-testing policies at each of the drug court sites but only two programs use a randomized drug testing protocol. At the two other drug courts, drug testing is random only insofar as clients do not know whether they will be tested on the day of their scheduled treatment session or drug court status hearing.

This chapter also addressed several issues about the integrity of these drug court programs. By comparing policy level findings about target populations with participant level data about actual criminal substance use histories, we found consistency between drug court policies and participant level information.

Nationally, drug courts attempt to reduce recidivism and drug use through the use of graduated sanctions, drug testing and substance abuse treatment. The drug courts in this study attempt to enhance alcohol and drug treatment with institutionalized policies and procedures that include substance abuse treatment, graduated sanctions and drug testing.

Chapter 4

Organization of Treatment Services

Overview

The main purpose of the drug court program lies in the provision of substance abuse treatment services. This chapter examines the delivery of substance abuse treatment services and the organizational characteristics of the treatment delivery system. It identifies commonalities and differences in the range of available treatment interventions among the providers at these four sites. In particular, we examine the structure, funding, and component services offered as part of the treatment delivery system.

Methods

Information presented in this chapter is derived from multiple data sources including interviews with key team members and administrators such as drug court judges, case managers, prosecutors, public defenders, and sheriffs. In addition, each court provided official program documents (typically the policy and procedures manual and client handbook[7]). Also, each director of treatment associated with these courts (except in Bakersfield where a sample of the programs serving the largest number of drug courts were studied and multiple program directors were surveyed) completed a survey that provided more in depth information. Supplementing the survey was an onsite interview used to clarify any details from the survey itself. Respondents were allowed to provide their best estimates of some information. While this presents possible difficulties in terms of the accuracy of some of the information provided to the evaluators, due to the small size of the programs, it was assumed that the approximations would be very close to the actual situation in question.

The chapter is organized as follows. The next section provides an overview of the substance abuse delivery systems. It is followed by an examination of the treatment system from the perspective of criminal justice personnel. The final section of the chapter examines the delivery systems from the perspective of the treatment personnel.

Treatment Service Structures According to Drug Court Personnel

The first series of results are based on information collected from drug court personnel. According to the drug court staff, the major substance abuse treatment service component is delivered in an outpatient setting. Both treatment and court personnel

[7] A more complete description of these procedures is found above in Chapter 2.

report that outpatient treatment is typically delivered in a model where the client moves from most intensive to least intensive treatment structured around specific phases[8].

Nationally, Peyton and Gossweiler (2001) found that most drug courts obtain treatment services directly through dedicated providers with whom they have some formal agreement. This was found at three of the four drug courts in this study (St. Mary Parish, Creek County, and Jackson County). The exception is the Bakersfield drug court that utilized multiple external treatment providers assigning drug court clients to dedicated slots located within geographical proximity of the clients' residence.

Substance abuse treatment services such as relapse prevention are typically obtained through referrals to other agencies located in the community. The use of these referral/brokerage services has the potential to extend drug treatment beyond the boundaries of the drug court program itself. Relationships with providers external to the primary treatment agencies are less formal and varied. Informal arrangements are typically made with these providers on an as needed basis.

Table 4.1 summarizes drug court case managers' reports of the types of direct and referred drug treatment services available. Each of the four sites in this study provides access to a variety of treatment services but there are broad variations in the number and types of services available and whether they are delivered by direct providers (i.e. associated with the court) or external providers (i.e., through a referral to another community service agency). In comparison with the Jackson County and St. Mary Parish sites, the Creek County and Bakersfield sites are more reliant on referrals to external programs to provide treatment and ancillary services. Overall, participants tend to be referred out for detoxification services and residential treatment. However, other types of referrals include community-based therapeutic communities, relapse prevention, and outpatient treatment. None of the programs in this study provide a methadone maintenance intervention. However, one drug court did provide Naltrexone pharmacological treatment.

Two of the direct providers are fairly robust in the number and types of services they offer. In Jackson County such services include residential treatment, intensive outpatient, outpatient services, and relapse prevention and a therapeutic community. Overall, the direct service provider at St. Mary Parish drug court offers more types of services than other sites. In fact, the direct provider offers 73% of the twelve services listed in Table 4.1. The corresponding figures for services provided by the direct providers at the other sites are: 36% at Creek County and 55% at the Jackson County site respectively.

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[8] Generally, though, it appears that this "phased-system of treatment services" means simply that requirements for treatment attendance and drug testing frequency are gradually decreased. As discussed below in Chapter 6, observers of treatment services themselves could rarely discern the phase of a given treatment session or meeting, suggesting that the treatment as actually delivered is typically invariant across phases of treatment. In other words, it was not possible for our observers of the treatment activities themselves to notice any different focus of treatment across meetings purporting to be of different phases. We return to this issue in Chapter 7 when results of the direct observations are reported more fully. Generally, treatment administrators reported that clients participate in the particular modality offered to them for fixed lengths of time. Other treatment and ancillary services are reportedly made available through referrals to external agencies.

Overall, drug treatment services reported as available at the four sites in this study are comparable to those reported as available in 212 drug court sites surveyed nationally by Peyton and Gossweiler. Across the board, treatment services provided at these four sites do not necessarily represent the standard of care with "highly individualized placements and lengths of stay in one or more treatment modality contingent on individual client needs" described by the Ten Key Components (DCPO). However, each of the four sites does attempt to provide access to a variety of treatment services using either informal referrals or in fewer cases, direct service provision.

Table 4.1 Types of Direct and Referred Drug Treatment Services Available

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Peyton and Gossweiler*	
	Direct	Referred	Direct	Referred	Direct	Referred	Direct	Referred	Direct	Referred
Residential	Yes	Yes	No	Yes	No	Yes	No	Yes	68%	80%
IOP	Yes	No	No	No	No	Yes	Yes	No	89%	51%
Outpatient	Yes	Yes	Yes	Yes	No	Yes	Yes	No	83%	51%
Detoxification	Yes	Yes	No	No	No	Yes	No	Yes	55%	67%
Alcohol/Drug Education	Yes	No	No	No	No	Yes	No	No	75%	49%
Methadone Maintenance	No	No	No	No	No	No	No	No	20%	34%
Other Pharmacological Interventions	Yes	Yes	No	No	No	No	No	No	19%	16%
Community Based TC	Yes	Yes	No	No	No	Yes	Yes	No	36%	37%
Acupuncture	Planned	No	No	No	No	No	No	No	27%	17%
Relapse Prevention	Yes	Yes	Yes	No	No	No	Yes	No	81%	49%
Other	No	No	Mentoring Program	No	No	No	No	No	11%	10%
Number of Services	8	6	3	2	0	6	5	1	NA	NA
Percent of Direct Services	73%		36%		0%		55%		NA	

Treatment Structures Organization from the Perspective of Treatment Personnel

Treatment Funding Issues

The following information about treatment structure and organization was obtained from interviews and surveys completed by treatment administrators. Table 4.2 summarizes variations in the types and level of funding across sites. Overall programs vary considerably in the size of their operating budgets ranging from a low of $45,000 annually to over $1 million. Only two of the sites report receiving funds from federal sources - primarily from the Department of Justice. All of the sites rely on state funding from criminal justice or mental health agencies or general funds. In addition, three of the four programs receive funding from either local or private (client fees) sources. There

are rural/urban differences in the size of these operating budgets with urban drug courts sites having substantially more funding.

The largest proportion of the programs' budgets allocated to providing services for drug court clients varied across sites, though several seemed to focus their resources on group treatment services, likely reflecting a need to maximize treatment dollars by providing services to many offenders at once. Finally, this group of administrators varied widely on what they reported they would spend any additional monies on, were they to become available, likely reflecting specific perceived local needs. Such needs range from staff training, case management and additional group and individual counseling services.

Table 4.2 Financing of Treatment Programs

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient‡	Residential	Outpatient	Residential
Overall Program Budget (in thousands of Dollars)	$250-$500	$45-$90	$1,000+ (2) $90-250 (1) $45-90 (1) N/R (1)	$1,000+ (a)	$500-$1,000	$1,000+
Federal Sources	US DOJ	None	SAPI (2) US DOJ (1) N/R (1)	None (a & b)	US DOJ	None
State Sources	Office of Alcohol and Drug Abuse	Dept. of Mental Health & Substance Abuse	State CJ Agencies (3) Medicaid (3) General Fund (3)	State CJ Agencies (3) (a & b) Mental Health/Work Programs (b)	State CJ Agency	State General Funds
Local Sources	County Tribal	None	County (1) Other (1)	County Funds[a]	Local Taxes	Local Taxes
Private Sources	Client Fees	None	Client Fees (2)	Client Fees (2)	None	None
Largest Portion of Program Budget	32% Treatment Adjuncts	50% Group Treatment Services	30% Group (1) 25% Individual(1) N/R (3)	45% Case Management (a)	52% Individual Treatment Services	55% Group Treatment Services
First Choice for Any Additional Funds	Staff Training	Group Treatment Services	Group (1) Individual (1) Adjuncts (2)	Individual Tx. (a) Facilities (b)	Staff Training	Case Management

a- Residential Treatment Program "a", large, male-female facility
b- Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Treatment Program Organizational Structure

A pattern of diversity emerges (see Table 4.3) with regard to the overall structure of the treatment programs at these four sites. Treatment program administrators at the Bakersfield and Creek County sites described their agencies as independent, community-based, non-profit organizations, while the treatment program at St. Mary Parish and Jackson County site were described as being more directly affiliated with the drug court

itself. Many administrators describe their programs as community-based, non-profit agencies with several reporting affiliation with larger community service agencies. A professional manager ran most programs, (e.g., a Chief Executive Officer) while the treatment provider at St. Mary Parish was part of a state agency.

At all four drug court sites, providers commonly described their services as either intensive outpatient or outpatient drug-free, with two programs reporting residential services, services for dually-diagnosed clients, and services for women with children.

Table 4.3 Treatment Program Organizational Structure

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ (# Programs)	Residential	Outpatient	Residential
Organizational Structure	Community-Based, State Substance Abuse Agency	Non-Profit Community Service Agency	Non-Profit (3) Local MH Agency (2)	Non-Profit, Community Services Agencies (a & b)	Independent Agency	Non-Profit, Community Services Agency
Larger Agency?	State Government	Yes, same as above (2 other units)	No (3) Yes (2)	Yes, same as above (a & b)	No	Yes, same as above
Who Runs Agency?	County Government	CEO	CEO (4) Board (1)	CEO (a & b)	N/A	CEO
Program Activities	Inpatient? Intensive Outpatient and Self-Help	Outpatient Drug-Free and Intensive Outpatient	Outpatient Drug-Free (5) Intensive Outpatient (3) Dual Diagnosis (2) Women w/ Children (2)	Detox & Residential (a & b) Dual diagnosis (a) Women & Kids (b)	Outpatient Drug-Free, Intensive Outpatient and Dual Diagnosis	

a - Residential Treatment Program "a", large, male-female facility
b - Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Delivery of Specific Substance Abuse Treatment Services

Results presented in Table 4.4 provide more specific detail about the nature of the services reported by program administrators. Nearly all programs report offering individual, group, general substance abuse, relapse prevention, social/coping skills, and self-help (12-steps) interventions directly. In addition, it was common for these programs to offer family treatment sessions, anger management, follow-up counseling and case management service directly to their clients. While administrators report offering many of these services directly to clients, some of these service areas were not always observed (See Chapter 7 for more on this issue) during the site visits (e.g., family, educational and aftercare activities).

Table 4.4 Specific Substance Abuse Services

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ (# Programs)	Residential (b only)	Outpatient	Residential
Individual Counseling	Not Available	Direct	Direct (4)	Direct	Direct	Direct
Group Counseling	Direct	Direct	Direct (4)	Direct	Direct	Direct
General Substance Abuse	Direct	Direct	Direct (4)	Direct	Direct	Direct
Relapse Prevention	Direct	Direct	Direct (4)	Direct	Direct	Direct
Social & Coping Skills	Direct	Direct	Direct (4)	Direct	Direct	Direct
12 Step/Self-Help	Referral	N/A	Direct (3) Referral (1)	Direct	Referral	Direct & Referral
Life Skills	Referral	Referral	Direct (4)	Direct	Direct	Direct
Vocational Skills	Referral	Referral	Direct (2) Refer (2)	Direct	Referral	Referral
Anger Management	Referral	Direct	Direct (3) Referral (1)	Direct	Direct	Direct
Family Sessions	Direct	Direct	Direct (2) N/A (2)	Direct & Referral	Direct	Direct
Follow-up Counseling	Direct	Direct	Direct (3) N/A (1)	Direct & Referral	Direct	Direct
Case Management	Direct	Direct	Direct (4)	Direct	Referral	Direct & Referral
Other	N/A	Drug Tests- Direct & Referral	Aftercare- Direct (1) N/A (4)	Aftercare- Direct	N/A	N/A

b - Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Substance Abuse Program Structure & Duration

In terms of the duration of the treatment programs, again variations in the number and length of specific program phases were reported (see Table 4.5). Many programs reported information on the structure of program phases that appears to reflect their ideal rather than actual practices, while some programs did not provide even ideal lengths of stay in various phases of treatment. In general, according to program administrators' reports introductory phases of treatment appeared to last from 2 to 4 months, at which time clients would begin to move into more intensive treatment stages, where again they could spend from 3 to 4 months, before moving to what was usually a final transition phase.

The outline shown in Table 4.5 represents a very general summary of the information provided in that programs overall reported vastly different time frames and numbers of distinct treatment phases (from 2 to 4 phases). The St. Mary Parish program appears to be the most well organized in terms of its use of structured program phases, including the use of a follow-up phase (4) and specific written goals to be accomplished

in each phase of treatment. Other programs did not appear to be as well organized in their use of graduated phases of treatment delivery. In fact, it was often difficult for observers of meetings to determine what phase of treatment a given group was intended to be a part of.

Table 4.5 Substance Abuse Program Structure & Duration

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ (# Programs)	Residential	Outpatient	Residential
Phase 1	8 weeks	3 months	6 months (1) N/R (4)	4 months (a) 1-2 days (b)	16 weeks	N/R
Phase 2	16 weeks	3 months	90 days (1) N/R (4)	4 months (a) 1-2 days (b)	16 weeks	N/R
Phase 3	12 weeks	3 months	N/R (5)	4 months (a) 4-100 days (b)	16 weeks	N/R
Phase 4	24 weeks	N/A	N/R (5)	N/A	N/A	N/R
Closed Groups	No	No	Open (5) Both (2)	No (a&b)	No	No
Formalized Curriculum	No	Yes	Yes (3) No (2)	N/R (a) Yes (b)	Yes	Yes

a - Residential Treatment Program "a", large, male-female facility
b - Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Delivery of Medical Services

Referring to the delivery of medical services (Table 4.6), it appears that the majority of programs referred clients to other agencies, with the exception of the residential program at the Jackson County site (which was part of a larger community service agency which itself included divisions responsible for community health services). While it would not necessarily be expected that drug treatment service providers offer medical services, the ability to provide these services to a population that is likely to have multiple co-occurring medical issues, is no doubt a benefit to the clients in residential treatment at Jackson County.

Table 4.6 Ancillary Medical Services Delivered

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ (# Programs)	Residential (b only)	Outpatient	Residential
Adult Primary Care	N/A	N/A	Referral (4) N/R (1) Referral (4) N/R (1)	Referral	Referral	Direct
Pediatric Care	N/A	N/A	Referral (4) N/R (1)	Referral	N/A	Direct
Prenatal Care	N/A	N/A	Referral (4) N/R (1)	Referral	N/A	Direct
Post Partum Care	N/A	N/A	Referral (4) N/R (1)	Referral	Referral	Direct
Physical Exams	N/A	N/A	Referral (3) N/R (2)	Referral	Referral	Direct
TB Testing	Direct	N/A	Referral (4) N/R (1)	Referral	Referral	Direct
STD/VD Testing	Direct	N/A	Referral (4) N/R (1)	Referral	Referral	Direct
HIV Testing	Direct	N/A	Referral (4) N/R (1)	Referral	Referral	Direct
Medical Detoxification	Referral	N/A	Referral (2) N/R (3)	Referral	Referral	Referral
Methadone Treatment	N/A	N/A	Referral (3) N/R (2)	Referral	N/A	Referral
Prescribed Medication	Referral	N/A	Referral (2) Direct (1) N/R (1)	Referral	Referral	Direct
Birth Control	Referral	N/A	Referral (3) N/R (2)	Referral	Referral	Direct
Acupuncture	N/A	N/A	N/A (4) N/R (1)	N/A	Referral	Referral
Other	N/A	N/A	N/A (4) N/R (1)	N/A	N/R	N/R

b - Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Delivery of Other Ancillary Services

The delivery of other social and treatment services to clients involved in drug court treatment occurs primarily through referrals to other agencies according to administrators' reports (see Table 4.7). With the exception of some aftercare services provided directly by the treatment programs at Bakersfield, St. Mary Parish and Jackson County, many other services such as vocational interventions, transportation and housing are provided via referral to other agencies. Similarly, services for specific groups, the hearing and sight impaired and Spanish speakers did not tend to be offered "in house" by these programs.

Table 4.7 Other Ancillary Services Delivered

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ (# Programs)	Residential (b only)	Outpatient	Residential
Academic	Referral	Referral	Direct (1) Referral (2)	Referral	Referral	Referral
Job Training	Referral	Referral	Direct (1) Referral (3)	Referral	Referral	Referral
Career Counseling	Referral	Referral	Direct (1) Referral (3)	Direct & Referral	Referral	Referral
Job Placement	Direct	Referral	Direct (1) Referral (2)	Referral	Referral	Referral
Other Career Services	Direct	Referral	Direct (1) Referral (2)	Referral	N/R	Referral
Locating Housing	N/A	Referral	Direct (2) Referral (2)	Referral	Referral	Referral
Transportation	Referral	Referral	Direct (3) Referral (1)	Direct	Referral	Direct
Legal Assistance	Direct	Referral	Referral (3)	Referral	Referral	Referral
Spanish Services	N/A	Referral	Direct (3) Referral (1)	Direct	Referral	Referral
Sight Impaired Services	N/A	Referral	Direct (1) Referral (3)	N/A	Referral	Referral
Hearing Impaired Services	N/A	Referral	Direct (1) Referral (3)	Direct	Referral	Referral
Aftercare-Intensive Outpatient	Direct	Referral	Direct (3)	Referral	Direct & Referral	Direct
Aftercare-Outpatient Drug-Free	Direct	Referral	Direct (2)	Referral	Direct & Referral	Direct
Aftercare-Residential	N/A	Referral	Direct (1) Referral (1)	Referral	Referral	Direct
Aftercare-12 Steps/Self Help	Referral	Referral	Direct (2) Referral (1)	Direct	Referral	Direct
Aftercare-Vocational Education	N/A	Referral	Referral (2)	N/A	Referral	Referral

b - Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the survey.
‡- Information is presented for all five of the outpatient programs examined at this site.

Aftercare

Aftercare services create the possibility of continuity for participants who have received substance abuse treatment services and can introduce some quality control for participants who have completed the treatment program. As indicated above, administrator surveys indicate that either direct or referred aftercare services are provided by treatment providers.

Court personnel interviews were not as conclusive about aftercare services as treatment administrators. They indicate that the whether aftercare is provided in these drug court programs is partly a definitional issue. For example, the aftercare program at the Jackson County site consists of graduates voluntarily attending twelve-step meetings. The three-month aftercare program at the Bakersfield site consists of one monthly drug

test. In Creek County, some graduates with felony convictions are still on probation and receive probationary supervision as "aftercare".

Finally, the aftercare program at the St. Mary Parish appears to be part of the treatment program. Court personnel report an aftercare program at St. Mary Parish consisting of the fourth phase of the program, "Continued Care". It is six months long consisting of one drug test, attendance at two treatment sessions, and three AA meetings a month. Other court personnel report that only some graduates at St. Mary Parish receiving aftercare services and only because they are still on probationary supervision. The treatment provider offers a voluntary aftercare maintenance program. Despite these provisions, based on court personnel interviews it does not appear that the provision of a specifically designed post-graduation aftercare program exists at any site.

Summary

Overall, information in this chapter suggests that an array of direct and referred services are available to treat a variety of substance abuse and associated problems of drug court participants. According to reports of both treatment and drug court personnel, a direct provider delivers the bulk of the substance abuse treatment services at three of the four drug court programs while other services such as medical and other ancillary social services are made available to participants through an informal referral system.

The direct providers are delivering what they describe as outpatient or intensive outpatient services in a group format consisting of a fixed-length, step-down program delivered in phases. However, there are considerable cross-site variations in the nature and type of services provided, the number of phases and the length of each phase. The direct provider at St. Mary Parish also offers a range of services including residential treatment and the direct provider at the Jackson County site also offers residential treatment. Other than the provision of direct outpatient substance abuse treatment services, the Creek County treatment provider is a stand alone service referring participants out to other agencies for most services.

In general, the treatment providers at these sites have budgets that vary in size in relation to the surrounding populations they serve, with urban providers having larger budgets. Most programs rely heavily on state funds and vary in the priority they place on funding various types of treatment activities.

At the onset of this chapter, we discussed the fact that the provision of access to a continuum of alcohol, drug and other related treatment and rehabilitation services is one of the *Key Components* (4th) of drug courts. It appears that there are several impediments to the delivery of this type of "continuum of care", including the reliance on informal referral systems for the provision of ancillary services. This is especially pronounced in courts where multiple substance abuse treatment providers are utilized (e.g. Bakersfield) or where the primary drug treatment providers are predominately community-based programs. We return to this issue in Chapter 7 – Integration of Treatment Services, but it appears that the form of relationship that exists between the court and the substance abuse treatment agencies can have important impacts on the nature and extent of service delivery (in terms of both substance abuse and ancillary services).

At each site, when particular services are not directly provided, attempts may be made to refer participants to other agencies for those services. However, there was no indication at any site that direct providers were substantively involved in ensuring that participants received those services for which they were referred.

It may be unfair to expect these programs to provide a wide spectrum of non-drug related services directly to clients. However, to the extent that these client populations suffer from multiple social, interpersonal and psychological needs, the reliance on informal referral systems, without formalized cooperative agreements with external providers may well hamper the ability of the drug court to effectively provide the entire range of services necessary for the high need, high risk criminal justice populations they serve.

Chapter 5

Treatment Counselors' Perspectives on Drug Treatment Services

Overview

This chapter presents information gathered from surveys of treatment counselors at each of the treatment agencies involved in the evaluation of these four adult drug court programs. Information gathered through the surveys includes that related to the qualifications, experience and philosophical orientation of counselors, as well as their typical daily activities. In addition, information about client characteristics (drug of choice, demographics), as well as staff characteristics is presented as reported by the program administrators on the Administrator's Survey. A full discussion of these two surveys can be found in Chapter 2.

Treatment Program Staffing Issues

The following section presents information collected from Administrator surveys regarding the characteristics of the clinical and other staff employed by the treatment programs utilized by these four drug courts. As can be seen in Table 5.1, the number of clinical and other staff varies with the overall size of the program. Fortunately, most of the treatment programs seem to employ large proportions of clinical staff, relative to the numbers of other staff (clerical, management, security). On the other hand, few programs report employing large numbers of security staff (which may not be crucial in predominately outpatient programs), medical staff or case management staff. The lack of medical staff appears consistent with results presented above concerning the referral of clients for needed medical care, however the relatively low numbers of case managers in these programs might suggest that responsibility for activities such as transitional planning and referral to adjunctive social services may be pushed onto clinical staff, or that these activities are not given sufficient priority within the programs.

Table 5.1 Staffing Levels

	St. Mary Parish	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient ‡ *Avg. Full Time Equivalent*	Residential	Outpatient	Residential
Managers/Supervisors	3/0	1/0	1.5	3 (a) 4 (b)	2/0	2/0
Clinical Staff	4/0	1/2 +1 Contract	5.4	12 (a) 11 (b)	6/11 +1 Contract	20/0
Medical Staff	0	0	1	0	0/0	0/1
Security Staff	0/1	0	0	2 (a) 0 (b)	0/0	0/1
Clerical Staff	2/1	1/0	3.5	2 (a) 1 (b)	4/2	1/0
Case Managers	2/0	0	1 (all 5 at one program)	1 (a) 1 (b)	0/0	0/0
Other			0	16 House Mangers (b)		
Total	11/2	6/0	12	20 (a) 33 (b)	13/13	23/2

a- Residential Treatment Program "a", large, male-female facility
b- Residential Treatment Program "b", smaller, all female facility
† - Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the administrator's survey.
‡- Average Full Time Equivalent positions per treatment program. This aggregated information is presented for all five of the outpatient programs examined at this site.

Results presented in Table 5.2 demonstrate what is a common finding in correctional and substance abuse treatment programs in general, specifically that many of the clinical staff employed in these programs have relatively low levels of education (the majority have Bachelor's degrees or less). On the other hand, compared to their educational achievements, relatively large proportions of the clinical staff do hold some type of appropriate substance abuse treatment credentials. Also, among those who reported on the recovery status of their counselors it was not uncommon for clinical staff in these programs to be recovering substance abusers themselves. This finding is also relatively common in the substance abuse treatment literature.

Table 5.2 Clinical Staff Qualifications/Experience

Staff Qualifications	*St. Mary Parish*	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient‡ *Mean (N) [Range]*	Residential	Outpatient	Residential
M.D.	0	0	0.6 (5) [0-1]	0	0	1
PA/NP	0	0	0	0	0	0
RN/LPN	0	0	0.2 (5) [0-1]	0	0	1
Ph.D.	0	1	0.2 (5) [0-1]	0	0	0
Master's	0	2	1.2 (5) [0-4]	1 (a) 0 (b)	12	5
Bachelor's	5	3	1 (5) [0-3]	2 (a) 1 (b)	1	4
High School or less	8	0	3 (5) [0-8]	N/R	1	12
Recovering	6	1	5.5 (2) [4-7]	N/R	9	7
Certifications/Licensures	5	N/R	3.8 (4) [1-6]	2 (a) N/R (b)	8	7

a- Residential Treatment Program "a", large, male-female facility
b- Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program, which served most of the court's clients during this time, did not complete the administrator's survey.
‡ - Information is presented for all five of the outpatient programs examined at this site (Mean number of positions of each type, per program; Number of programs responding; Range of the number of positions of each type at each program).

In general, the response rate for counselor surveys varied across sites (see Table 5.3). In Creek County, the program that lost its contract to provide services to drug court clients during our visit, failed to return the majority of our surveys. While the overall response rate was 60%, information was obtained from counselors from every program in every jurisdiction. Most counselors reported working 40 hours per week and had relatively large numbers of clients assigned to them (as many as 35 clients in some programs). Overall, the counselors varied in their racial background, with few African American counselors in most of the programs. Also, many of the programs did not employ any Hispanic counselors. These results could be expected to negatively impact the delivery of culturally appropriate treatment. While most counselors reported their age as around 40 years old, there was some variation, with St. Mary Parish employing somewhat younger counselors. Most counselors had been with their respective treatment programs for at least 2 years and many had a number of years experience providing substance abuse treatment and other social services to offender populations.

Table 5.3 Clinical Staff Characteristics

Staff Characteristics	*St. Mary Parish*	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient‡	Residential	Outpatient	Residential
Number of Respondents (Response %)	3 (50%)	3 (30%)	21 (62%)	16 (84%)	8 (53%)	3 (30%)
Mean % in Recovery	0	2/3	38%	94%	50%	1/3
Modal Highest Degree Held (Proportion w/modal degree)	BA (3/3)	Ph.D. (1/3) M.A. (1/3) H.S. or less (1/3)	H.S. or less (48%)	H.S. or less (81%)	B.A. (50%)	B.A. or some College (3/3)
Mean Hours Worked per Week	40	27.2	40.3	40.3	30.0	40.0
Mean Number of Clients	76.7	28.7	34.3	12.2	25.0	24.3
Mean % of White Counselors	1/3	2/3	19%	81%	38%	1/3
Mean % of African American Counselors	2/3	1/3	24%	0%	25%	2/3
Mean % of Hispanic Counselors	0	0	38%	0%	0	0
Mean Age in Years	28.7	51.0	42.2	40.8	36.5	42.0
Mean Years with this Program	1.9	2.2	2.8	1.8	2.1	5.0
Mean Years Providing Drug Treatment	4	2.5	4.7	3.2	6.1	6.0
Mean Years Providing Social Services	4	11.6	10.2	4.3	6.6	8.1
Mean Years Working with Offenders	4.5	3.1	5.6	4.7	6.0	9.4

† - Aggregated data is presented based on information from counselors at both treatment programs.
‡- Means for each category are presented which summarize the information provided by all responding counselors at all five of the outpatient programs examined at this site, as well as from the two residential programs.

Most counselors report conducting about one group activity per day, of approximately 10 to 15 clients per group, for approximately one to one and a half hours per meeting (see Table 5.4). They also report having one or two individual sessions per day, lasting anywhere from 30 minutes to approximately an hour. Other activities vary widely by site, but few programs appear to spend substantial amounts of time involved in family counseling. This result from the counselor surveys contradicts data from the program administrators who generally reported that the programs did, in fact provide family counseling services directly to their clients. Generally, this group of counselors reported spending a good deal of time on admissions-related duties, but did not report what would seem to be a large amount of time spent on related assessments.

Table 5.4 Treatment Staff -Related Activities

Staff Activity Type	*St. Mary Parish*	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient‡	Residential	Outpatient	Residential
Mean Weekly Number of Groups (Hours/Week)	3.0 (6.2 hrs)	5.7 (8.0 hrs)	4.7 (8.2 hrs)	4.7 (5.4 hrs)	4.3 (6.8 hrs)	3.0 (8.2 hrs)
Mean Clients per Group	13.5	9.7	10.1	21.2	13.1	7.7
Mean Weekly Individual Sessions (Hours/Week)	3 (3.5 hrs)	1.3 (0.7 hrs)	8.3 (4.8 hrs)	7.2 (9.5 hrs)	13.2 (13.8 hrs)	11.5 (15.2 hrs)
Mean Weekly Number of Assessments (Hours/Week)	1 (1.5 hrs)	0	4 (4.4 hrs)	1.4 (2.8 hrs)	1.9 (3.4 hrs)	2.8 (4.5 hrs)
Mean Weekly Hours of Case Management	13.3	4.0	6.9	8.4	3.6	2.0
Mean Weekly Hours of Discharge Duties	1.0	2.0	2.5	2.5	1.0	2.0
Mean Weekly Hours of Family Counseling	0	0	1.5	1.3	0	1.5
Mean Weekly Hours of Admissions	5.5	4	11.0	8.7	0	2.5
Mean Weekly Other Duties	1.0	0	3.2	4.4	2.5	1.5

†- Aggregated data is presented based on information from counselors at both treatment programs.
‡- The mean for each category is presented which represents the information provided by all responding counselors from all five of the outpatient programs examined at this site, as well as from the two residential programs.

Results presented in Table 5.5 suggest that all of the programs involved in this evaluation make use of a standard intake-screening tool, most commonly the Addiction Severity Index. Nearly all of the counselors responding to the survey felt the tool was useful. Nearly all counselors also reported that their programs used individualized treatment plans for their clients, but very few reported that the client was involved in the development of these plans. Most counselors reported spending about five hours per week on treatment planning activities and that their clients' plans were commonly updated "as needed" without specifying how frequent that might be.

Table 5.5 Intake and Treatment Planning Activities

Intake/Planning Items	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Program Uses Intake Screening Tool	Yes (3/3)	Yes (100%)	Yes (100%)	Yes (100%)	Yes (100%)	Yes (100%)
Typical Tool	ASI (3/3)	SASSI (2/3)	ASI (86%)	ASI (100%)	ASI (50%)	ASI (67%)
The Tool is Useful	Yes (2/3)	Yes (3/3)	Yes (95%)	Yes (100%)	Yes (100%)	Yes (100%)
Individualized Treatment Plans	Yes (3/3)	Yes (2/3)	Yes (100%)	Yes (100%)	Yes (100%)	Yes (100%)
Who Creates or Updates Plan	Staff (2/3) Staff & Client (1/3)	Staff (3/3)	Staff (71%)	Staff (56%)	Staff (88%)	Staff (67%)
How Often Updated	90 days (3/3)	As Needed (1/3) Less than Monthly	As Needed (43%)	As Needed (63%)	As Needed (38%)	Monthly (67%)
Mean Weekly Hours Planning Treatment	2.7	1.0	5.4	4.6	4.7	9.5

† - Modal data is presented based on responses from the counselors at both programs.
‡- modal response for each category is presented based on information from all responding counselors from all five of the outpatient programs examined at this site, as well as from the two residential programs.

Substance Abuse Treatment Curricula

Almost all of the responding counselors reported that their programs used a formal curriculum in the provision of drug abuse treatment, with the exception of 2 out of 3 counselors from the St. Mary Parish site (see Table 5.6). However, observers noted that the St. Mary Parish site does use a structured curriculum in the first phase of treatment, so it is likely that these counselors were referring to the later phases of treatment. Generally, the counselors felt positively about these treatment curricula, rating them as effective and appropriate for their clients. This group of counselors also reported frequent use of videotapes, workbooks and to a lesser extent journal or diaries and audiotapes as treatment adjuncts.

Table 5.6 Formal Treatment Curricula Descriptions

Treatment Curricula Items	*St. Mary Parish* (percent "Yes")	*Creek County*† (percent "Yes")	*Bakersfield* ‡		*Jackson County*	
			Outpatient (percent "Yes")	Residential (percent "Yes")	Outpatient (percent "Yes")	Residential (percent "Yes")
Use Formal Curriculum	1/3	2/3	70%	57%	50%	67%
Curriculum is Effective	1/1	2/2	93%	100%	100%	100%
Clear to clients	1/1	2/2	79%	88%	100%	100%
Too Structured for Clients	0/1	0/2	14%	13%	0%	0%
Too Complex for Clients	0/1	½	14%	13%	0%	0%
Too Time Consuming	0/1	0/2	0%	13%	0%	0%
Too Basic for Clients	0/1	0/2	0%	13%	0%	0%
Not Relevant to Clients	0/1	½	14%	13%	0%	0%
Curricula Adjuncts						
Use Video Tapes	3/3	2/3	81%	75%	100%	100%
Use Audio Tapes	3/3	1/3	43%	50%	38%	33%
Use Workbooks	3/3	3/3	71%	81%	88%	100%
Use Journals or Diaries	3/3	2/3	48%	81%	50%	50%

†- Aggregated data is presented from counselors at both treatment programs.
‡- The mean number of counselors responding "yes" for each category is presented for all five of the outpatient programs examined at this site, as well as for counselors from the two residential programs.

Communicating Expectations and Monitoring Compliance

The majority of counselors in all sites reported that their programs used some form of behavior modification; with many reporting their programs used specific written contracts to reinforce appropriate client behaviors (see Table 5.7). Nearly all counselors reported that their clients were made known of the behaviors expected of them through some combination of verbal and written explanations. Programs appeared to be split as to whether the responsibility for explaining these expectations fell to the treatment or drug court staff.

Table 5.7 Communicating Expectations to Clients

Communication Items	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Use Behavior Modification	Yes 3/3	Yes 3/3	Yes 75%	Yes 67%	Yes 100%	Yes 33%
Use Written Behavioral Contract	Yes 3/3	Yes ½	Yes 89%	Yes 47%	Yes 100%	Yes 33%
Restricted Behaviors Made Known	Yes 3/3	Yes 3/3	Yes 95%	Yes 100%	Yes 100%	Yes 100%
Rules Made Known By Whom?	Drug Court Staff (3/3)	Treatment Staff (3/3)	Treatment Staff (47%)	Drug Court Staff (94%)	Drug Court Staff (63%)	Treatment Staff (100%)
Graduation Criteria Made Known	Written (3/3) Verbal (2/3)	Written (3/3)	Verbal (89%) Written (74%)	Verbal (94%) Written (69%)	Written (88%) Verbal (88%)	Verbal (100%)

†- Aggregated data is presented from counselors at both programs.
‡- The modal counselor response for each category is presented for responding counselors at all five of the outpatient programs examined at this site, as well as from the two residential programs.

All of the responding counselors reported that their clients were drug tested as part of participation in treatment, with the majority of programs reporting random testing (with unspecified frequencies). All counselors also reported that their agencies generated reports about clients' drug testing and shared those results with the drug court (see Table5.8).

Table 5.8 Drug Testing Procedures

Drug Testing Items	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Programs Drug Test Clients?	Yes	Yes (Both Programs)	Yes	Yes	Yes	Yes
Frequency?	Random	Random (Program a) Weekly (Program b)	Random	Random	Random	Random
Reports Generated?	Yes	Yes (Both Programs)	Yes	Yes	Yes	Yes
Reports Shared with Drug Court?	Yes	Yes (Both Programs)	Yes	Yes	Yes	Yes

†- Data is presented from counselor surveys from treatment staff at both treatment programs.
‡- The mode for each category is presented for all five of the outpatient programs examined at this site, as well as for the two residential programs.

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In terms of the consequences employed for negative behaviors, the counselors generally reported that their programs employed sanctions such as extra treatment sessions, additional attendance at support meetings, increased frequency of drug testing, homework assignments, and some restrictions on client privileges (see Table 5.9). Few counselors reported that their clients were fined for misbehavior or that their programs included token economies. As for rewards for positive behaviors, the counselors reported that common reinforcements included verbal praise from staff and other clients and the issuance of certificates. Other reinforcements were less

commonly reported, such as reductions in treatment attendance and drug testing frequency. These in particular varied by site and likely reflect policies of the overall drug court, more than the treatment programs themselves. For instance, in Bakersfield, the court had a relatively strict drug testing regime for clients, which likely explains the lower rates for the use of "decreased drug testing frequency" (only 13-26%, compared to 67% in St. Mary Parish). Again, the use of token economies and financial rewards were generally rare as reinforcements.

Table 5.9 Behavioral Consequences

	St. Mary Parish	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
Sanctions	(Percent "Yes")	(Percent "Yes")	Outpatient (Percent "Yes")	Residential (Percent "Yes")	Outpatient (Percent "Yes")	Residential (Percent "Yes")
Loss of Privileges	67%	33%	20%	100%	75%	67%
Extra Treatment	100%	100%	75%	47%	88%	67%
Extra Support	67%	100%	80%	33%	88%	100%
Homework	100%	67%	50%	93%	50%	100%
Extra Drug Testing	100%	100%	65%	47%	75%	33%
Fines or Fees	05	67%	1%	0%	63%	0%
Token Economy	33%	0%	1%	20%	25%	0%
Rewards						
Verbal Praise from Staff	100%	100%	85%	94%	100%	100%
Verbal Praise from Other Clients	33%	67%	75%	81%	100%	33%
Reduce Treatment	67%	33%	40%	87%	75%	0%
Reduce Drug Testing	67%	33%	26%	13%	88%	33%
Financial Rewards	0%	0%	0%	0%	71%	0%
Vouchers, etc.	0%	0%	15%	0%	88%	0%
Certificates	33%	67%	75%	100%	75%	33%
Token Economy	0%	0%	5%	0%	13%	33%

†- The mean number of respondents who reported, "yes" for each item is presented for both treatment programs.
‡- The mean number of respondents who reported, "yes" for each item is presented for all five of the outpatient programs examined at this site, as well as for the two residential programs.

Counselors' Philosophy of Drug Abuse and Effective Treatment

Counselors were asked to rate their agreement with several statements intended to capture information about their perspective on the likely causes of drug use and abuse, as well as their opinions about what components were needed for effective substance abuse treatment. Counselors rated their agreement with each of these statements using a five-point Likert scale ("1" = "strongly agreed with the statement", "5"= "strongly disagreed with the statement"). Each of these items was then aggregated into scales representing specific theories (e.g., Social Learning theory, Social Disorganization theory, etc). The average score, by site for all items on each of these theoretical scales are presented in Table 5.10.

According to these results, counselors at all sites tended to moderately endorse the disease model, cognitive-behavioral skills deficits, psychopathic characteristics, antisocial values, social learning theory, social control theory, and labeling theory as important causes of drug abuse. They tended to slightly disagree with items representing conflict, social disorganization, and strain theories. These results would tend to suggest that the counselors located the causes of drug abuse within the personalities and individual experiences of the drug

user, more so than as a result of external social influences. In terms of the important aspects of effective drug treatment the counselors tended to moderately endorse items representing nearly all of the scales (see Table 5.11). This pattern of results may suggest that counselors are willing to apply almost any technique in an attempt to reduce drug use. It may also suggest that they do not generally have a strong affiliation or understanding of any particular approach to treatment, or that they do not implement a coherent treatment strategy in their programs.

Table 5.10 Staff Philosophy of Drug Use Causation (1=Strongly Agree, 5=Strongly Disagree)

Mean Scores: Drug Use Cause Scales	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Conflict	3.4	3.5	3.2	3.2	3.5	3.8
Labeling	3.0	2.7	2.5	2.4	2.5	2.2
Social Control	2.6	2.8	2.2	2.2	2.2	2.6
Social Disorganization	3.7	3.1	3.2	3.4	3.4	3.1
Social Learning	3.0	2.0	2.1	2.5	2.4	2.5
Strain	2.9	3.3	2.8	2.9	3.5	2.9
Anti-social Values	2.4	2.9	2.5	2.7	2.7	2.4
Cognitive Skills Deficits	2.0	2.0	2.0	2.0	1.9	1.8
Disease Model	1.7	3.5	2.1	1.7	2.1	1.5
Psychopathy	2.5	2.8	2.1	2.5	2.5	2.5

†- Data is presented from counselors who responded from both of the treatment programs.
‡- The mean response for each scale is presented for counselors who responded from all five of the outpatient programs examined at this site, as well as from responding staff at the two residential programs.

Table 5.11 Staff Philosophy of Effective Drug Treatment (1=Strongly Agree, 5=Strongly Disagree)

Mean Scores: Effective Intervention Scales	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Conflict	1.4	1.8	1.8	2.1	2.2	2.5
Labeling	1.3	1.3	1.5	1.6	1.6	1.5
Social Control	1.0	1.6	1.6	1.5	1.4	1.3
Social Disorganization	1.8	1.8	1.9	2.0	1.9	1.8
Social Learning	1.8	1.7	1.5	1.5	1.3	1.7
Strain	1.6	1.5	1.5	1.5	1.2	1.7
Anti-social Values	1.8	1.8	1.6	1.7	1.4	1.6
Cognitive Skills Deficits	1.6	1.7	1.6	1.6	1.3	1.3
Disease Model	1.8	2.8	1.7	1.5	1.8	1.5
Psychopathy	1.8	2.8	1.9	2.6	2.3	2.3

†- Data is presented from counselors who responded from both of the treatment programs.
‡- The mean response for each scale is presented for counselors who responded from all five of the outpatient programs examined at this site, as well as from responding staff at the two residential programs.

Characteristics of Clients in Treatment

Interestingly, this group of program administrators reported vastly different proportions of clients who were referred to their overall treatment programs from the drug court (see Table 5.12). For example, in St. Mary Parish, where the treatment program was actually a part of the drug court itself (and was part of the state government) 80% of the clients were referred from the drug court. On the other hand, the residential program in Jackson County was part of a larger agency which served clients from multiple sources within the community and only reported 5% of its clients being referred from the drug court (the court in this site predominately used outpatient treatment for its clients, sending them to residential only if they had difficulties maintaining good standing in outpatient services). Somewhere in the middle is the group of outpatient treatment programs utilized by the drug court in Bakersfield. Given that this court chose to utilize existing treatment agencies in the community, who also served clients from multiple other sources, it is not a surprise that on average, these programs reported about 35% of their clients were referred from the drug court. Thus the nature of the relationship between the court and the treatment agencies can have a substantial impact on the way that client are assigned to services. This issue is discussed further in terms of court-treatment integration in later sections.

Table 5.12 Client Referral Sources

	St. Mary Parish	*Creek County*†	*Bakersfield* ‡		*Jackson County*	
			Outpatient *Mean (N) [Range]*	Residential	Outpatient	Residential
Drug Court	80%	5%	35.3 (3) {1-90%]	N/R	72%	25%
Other Courts	20%	95%	24.8 (4) [0-59%]	N/R	6%	25%
Other CJ Agencies	0%	0%	37.5 (4) [0-100%]	N/R	20%	40-50%
Self-Referred	0%	0%	4 (4) [0-11%]	N/R	1%	10%
Other Referrals	0%	0%	7.5% (4) [0-25%]	N/R	2%	20%

†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program which served most of the court's clients during this time did not complete the administrator's survey.
‡- Information is presented for all five of the outpatient programs examined at this site (Mean number of clients in each group, across all responding programs; Number of programs responding; Range of the number of clients in each group). Proportions reported as estimates, therefore they total more than 100%.

Table 5.13 Primary Drug of Choice

	St. Mary Parish	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient *Mean (N) [Range]*	Residential	Outpatient	Residential
Heroin	0%	0%	6.25 (4) [0-16%]	0% (b)	4%	0%
Powder Cocaine	3%	0%	10 (4) [0-3-%]	20% (b)	4%	0%
Crack Cocaine	18%	2%	38.8 (4) [0-60%]	75-80% (b)	40%	70%
Amphetamines	6%	50-60%	0 (4)	0% (b)	8%	5%
Barbiturates/Tranquilizers	6%	0%	11.3 (4) [8-16%]	0% (b)	4%	0%
Marijuana/Hashish	48%	30-40%	0 (4)	0% (b)	35%	10%
LSD	6%	0%	5.8 (4) [0-11%]	0% (b)	0%	0%
PCP	0%	0%	0 (4)	0% (b)	10%	0%
Inhalants	0%	1%	0 (4)	0% (b)	0%	0%
Over the Counter Drugs	0%	0%	11.8 (4) [4-23%]	0% (b)	0%	0%
Alcohol	11%	60%	6.25 (4) [0-16%]	0% (b)	0%	20%

b- Residential Treatment Program "b", smaller, all female facility
†- Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program which served most of the court's clients during this time did not complete the administrator's survey.
‡- Information is presented for all five of the outpatient programs examined at this site (Mean number of clients in each group, across all responding programs; Number of programs responding; Range of the number of clients in each group). Proportions reported as estimates, therefore they total more than 100%.

The clients in this group of drug courts also seemed to vary in terms of their primary drug of choice (see Table 5.13). For example, Jackson County seemed to predominately treat clients whose primary drug of choice was either crack cocaine or marijuana, while Sites 1 and 3 seemed to be serving a client population heavily involved with amphetamine use, and the largest group of clients at St. Mary Parish reported using primarily marijuana. To some extent these drug of choice results reflect the drug which is currently presenting the largest problem in each area, but to some extent these results may also reflect the perspective of each court as to what drug is a "problem" locally, particularly since only Creek County reported a large proportion of clients whose primary drug of choice was alcohol (which is commonly associated with criminal behavior, but whose may not carry the same societal outcry as a perceived methamphetamine "epidemic").

Table 5.14 Client Attrition
(Percent of Clients who left treatment program for corresponding reason)

Reason For Leaving	*St. Mary Parish*	*Creek County†*	*Bakersfield ‡*		*Jackson County*	
			Outpatient *Mean (N) [Range]*	Residential	Outpatient	Residential
Completed or Graduated	30%	50%	66 (3) [28-100%]	77% (a) 75% (b)	28%	80%
"Against Medical Advice"	1%	25%	0 (3)	N/R (a) 25% (b)	30%	5%
Returned to Prison or Jail	1%	0%	6.6 (3) [0-15%]	N/R (a & b)	10%	0%
Removed for Rule Violation	50%	25%	24 (3) [0-62%]	18% (a) N/R (b)	30%	15%
Referred to Another Level of Care	17%	0%	6.6 (3) [0-10%]	N/R (a & b)	0%	0%
Deaths	1%	>1%	0 (3)	N/R (a & b)	2%	0%

a- Residential Treatment Program "a", large, male-female facility
b- Residential Treatment Program "b", smaller, all female facility
† - Data is presented from the treatment program that served only a small proportion of drug court clients during the evaluation period. The program which served most of the court's clients during this time did not complete the administrator's survey.
‡- Information is presented for all five of the outpatient programs examined at this site (Mean number of clients in each group, across all responding programs; Number of programs responding; Range of the number of clients in each group). Proportions reported as estimates, therefore they total more than 100%.

Clients in these treatment programs tended to "successfully complete" treatment at widely different rates (see Table 5.14). It is important to note that these proportions are reported from the treatment providers and represent completion of the treatment program, not completion of the drug court requirements. In any event, in St. Mary Parish (where the court and treatment provider are parts of the same agency) as few as 30% of clients "successfully complete" treatment, while in Bakersfield anywhere from 66% to 76% of clients complete either residential or outpatient treatment successfully according to the programs themselves. Interestingly, as many as 30% of clients, in some sites are apparently permitted to leave treatment "against medical advice", despite their being mandated to treatment by the court. Very few clients are reportedly referred to another level of care or are returned to prison or jail, however varying proportions seem to be removed from treatment for failing to meet program rules and requirements.

Summary

In general, staff at these drug treatment programs tended to have relatively low levels of education, but some had professional licensures or certifications and histories of overcoming substance abuse themselves. Very few minority counselors were employed by these programs, despite many of them serving relatively large proportions of minority clients. In terms of daily activities, many counselors reported conducting a single treatment group (about one hour long) per day, along with one or two individual counseling sessions daily.

A substantial proportion of their time was spent on admissions related duties, but unexpectedly small amounts of time were spent conducting assessments given the amount of time dedicated to admission duties. All programs reported using a structured screening

instrument and developing individual treatment plans, but most sites reported little involvement of the client in the treatment planning process.

There was much more variability in terms of communicating expectations to clients, with some reporting that treatment staff were responsible for this, while others reported that drug court staff performed these tasks. There was also mush less consistent use of written contracts, with some programs relying on verbal communication of program criteria. All programs reported drug testing and sharing that information with the drug court staff. Some programs reported using behavior modification techniques, with the most common sanctions being items such as loss of privileges, extra treatment or support meetings, or increased drug testing. Typical benefits included verbal praise from counselors or other clients, with some programs reducing treatment or drug testing requirements as well.

Counselors' philosophies of the causes of, and effective treatment for substance abuse issues tended to suggest a eclectic approach, in that they commonly endorsed items from various scales in similar ways. This pattern of results likely indicates the lack of a coherent, consistent approach to the manner in which these counselors think about and respond to clients' drug abuse. The validity of this claim is supported by results presented in Chapter 6, that find that the services delivered to clients are often of an amalgamated nature, employing multiple, sometimes conflicting approaches at the same time.

Clients were typically males in their twenties, but racial and ethnic characteristics varied by site. The largest proportions of African American clients were reported in the large, Mid-western metropolitan site, while the largest proportion of Hispanic clients was reported in the California site. Primary drug of choice (crack cocaine, marijuana, and amphetamines were common in several sites) also varied considerably by site, reflecting each regions prevailing drug problem and court guidelines which sometimes restricted eligibility of alcohol-only abusers. Other characteristics such as employment and parental status also varied across sites, sometimes in response to court policies (some mandated employment while participating in the drug court). The proportion of clients graduating or successfully completing the treatment program (not necessarily the drug court program itself) also varied widely by site, possibly being influenced by court requirements, levels of drug testing and other supervision (as is commonly found with Intensive Supervision Probation programs).

Chapter 6

Direct Observations of Drug Treatment Activities

Overview

In this section results from the direct observation of group treatment activities are presented in an attempt to assess the nature of these treatment services, as they are actually implemented. The researchers attended varying numbers of meetings at each site, depending up the number of treatment programs operating in each jurisdiction and the number of meetings offered by the programs. The numbers of meetings observed in residential treatment programs in both Bakersfield and 4 were purposefully kept relatively small (see Table 6.1) given that small proportions of the overall drug court client population in these jurisdictions were actually referred to residential treatment (based on an examination of retrospective data provided by the courts themselves). As such the researchers made the decision to focus available resources (observers) on the more thorough examination of the typical (outpatient) services received by drug court clients in these jurisdictions.

It is worth noting that in Bakersfield, the court personnel reported that clients were most commonly referred to residential treatment because of their lack of housing, not in response to any perceived need for more "intensive" treatment. Residential clients in Jackson County were commonly participating in a short-term residential placement, as a result of difficulties encountered in one of the 3 levels of outpatient care typically offered to clients in this jurisdiction. After a short-term stay in residential treatment these clients typically returned to their previous outpatient programs.

Treatment Activity Characteristics

Overall the scheduled length of the typical treatment meeting in these programs ranged from one hour and ten minutes to approximately two hours, with an average scheduled duration of just under one and a half hours (see Table 6.1). In terms of the actual duration of these meetings (the amount of time elapsed between the time they began and when they actually ended, as opposed to when they were scheduled to end) was somewhat shorter. In fact, the average actual length of a meeting observed in all sites accounted for only about 80% of the total scheduled treatment time. Some of the "lost" treatment time represents time allotted for "breaks" in the middle of meetings (usually only about 5 minutes in duration), but some of this "lost" treatment time was also explained by meetings ending prematurely. In fact, meetings ending as much as 30 minutes before the scheduled end-time were not uncommon in this sample of observed treatment meetings. As a result of this "lost" treatment time, the amount of treatment time actually delivered in the average meeting, across all sites, represented only about 75% of the total scheduled treatment time. With the exception of sites 2 and 3, whose

programs had more defined treatment phases, the majority of the programs in the remaining sites did not conduct meetings that were identifiable as part of an specific treatment phase. The typical format for treatment meetings in all sites was a staff-lead discussion of various treatment issues. The one exception is Creek County, where clients commonly attended meetings in which they simply reviewed their assignments from treatment workbooks.

Finally, the outpatient programs in Bakersfield in particular seemed to have difficulty delivering all of the groups they were scheduled to during the week of the observations. In fact, across the 4 outpatient sites where the researchers observed meetings, 8 separate meetings were cancelled. In one site, where the researchers were scheduled to observe the only 5 English-speaking groups the program was to offer during that week, 2 of the 5 were cancelled. Unfortunately, clients were not made aware of these cancellations until they showed up for treatment (nor was the observer notified prior to the meetings' scheduled start times). Court staff and various clients in several programs in this site, reported that meeting cancellations were a common occurrence and a major concern for the court administration. This was also an issue that the court staffers admitted some difficulty in trying to resolve short of canceling contracts with the programs involved.

Table 6.1 Treatment Meeting Summary Characteristics

Treatment Characteristics	*St. Mary Parish*	*Creek County†*	*Bakersfield*		*Jackson County*	
			Outpatient†	Residential	Outpatient	Residential
Total Number of Meetings Observed	13	27	26	8	45	5
Scheduled Length (SL) in Minutes	122	97	84	71	69	78
Actual Length in Minutes (% of SL)	88 (72%)	59 (61%)	74 (88%)	55 (78%)	59 (86%)	70 (90%)
Minutes of Break (% of SL)	16 (13%)	5 (5%)	4 (5%)	0 (0%)	4 (6%)	2 (3%)
Real Treatment Time in Minutes[=AL-Breaks] (% of SL)	72 (59%)	54 (56%)	70 (83%)	55 (78%)	55 (80%)	68 (87%)
Meeting is Part of Phase?	100%	70%	38%	0%	31%	0%
Typical Meeting Format (%)	Staff Lead Discussion (69%)	Work Book/Homework Review (48%)	Staff Lead Discussion (69%)	Staff Lead Discussion (50%)	Staff Lead Discussion (60%)	Staff Lead Discussion (40%)

† - Numbers represent aggregated data across multiple treatment programs at these sites.

The average number of clients in the observed meetings ranged from about 7 to as many as 27 clients (see Table 6.2). Residential programs in this sample tended to have larger numbers of clients per group meeting. The proportion of male clients varied by site, but generally males made up the majority, with the exception of the outpatient programs in Bakersfield. In all jurisdictions except Jackson County, whites made up the majority of clients, though only slightly in Bakersfield. Interestingly, there appears to have been a disproportionate number of African American clients in residential treatment

(relative to the proportion in outpatient programs) in Bakersfield. Similarly, Hispanic clients appear to be more likely placed in outpatient, rather than residential treatment in Bakersfield. The reasons for these discrepancies are not known, although it is possible that African American clients in this jurisdiction were more likely to be homeless (the courts stated criteria for assigning someone to residential, rather than outpatient treatment). It is unclear why Hispanic clients would be more likely placed in outpatient care, than in residential, given that the proportions of white clients in each type of treatment are more symmetrical (suggesting it is not an effect related to relative rates of homelessness among non-black clients). Interestingly, these differences in type of treatment assignment by race/ethnic group do not appear in Jackson County, where residential treatment is used as a supplement for those clients experiencing problems in their outpatient program (rather than being assigned based on housing status as in Bakersfield)

Table 6.2 Summary of Client Demographics (Observed in Meetings)

Client Characteristics	*St. Mary Parish*	*Creek County †*	*Bakersfield*		*Jackson County*	
			Outpatient†	Residential	Outpatient	Residential
Number of Participants	14.2	6.7	6.7	25.0	14.2	26/2
% Male	75%	75%	44%	57%	85%	86%
% White non-Hispanic	63%	87%	53%	57%	13%	14%
% African American	34%	5%	8%	35%	85%	78%
% Hispanic	3%	7%	38%	6%	2%	6%

† - Numbers represent aggregated data across multiple treatment programs at these sites.

Clinical Features of Treatment Services

The following sections describe the specific treatment activities and topics covered during the sample of meetings observed in each of the 4 jurisdictions. These aspects of treatment delivery are categorized into several general domains including the management of the meeting (introducing new clients, dealing with group rules, building the sense of community and clients' motivation); cognitive-behavioral topics (dealing with current or alternative thoughts, feelings, attitudes, relapse prevention, problem solving); education and aftercare items (drug education, vocational education, parenting skills, relationships/co-dependency issues, cultural issues); safety and self-exploration (self-esteem, family issues, defense mechanisms, physical and psychological safety in the group); and 12-steps/Therapeutic Community items (confrontation by peers or staff, acceptance of powerlessness, making amends).

In terms of the management of this sample of meetings, issues of community management (e.g., reviewing the rules about how to appropriately participate in group discussions) were commonly used (i.e., a relatively large proportion of the observed meetings in each site) in many sites (see Table 6.3). In addition, motivation building (e.g., helping clients stay focused on treatment) was commonly observed in a large proportion of meetings, though usually this topic was not dealt with for extended periods of time when mentioned (only as much as 18% of total treatment time in residential meetings in Bakersfield). A traditional technique in group therapy, having clients "check in" (usually clients introduce themselves and discuss how they are currently feeling), was

also commonly used in most sites (in as many as 73% of all meetings observed in Bakersfield). As might be expected, the proportion of overall treatment time allotted to this activity was relatively brief (less than 25% of the meeting's actual duration in most sites). Many sites (almost 58% of observed meetings in Bakersfield outpatient programs) also commonly spent some time intended for treatment delivery to set up the room they were meeting in (e.g., arranging chairs). Other items in this category were less commonly observed or were discussed only for relatively short durations when they did occur. In particular, pull-ups (formalized confrontations about inappropriate client behaviors) and other forms of sanctions were rarely observed in these meetings, nor were relaxation-training techniques, or physical exercise commonly used.

Table 6.3 Management Items

Item % of Meetings† (%Time) ‡	*St. Mary Parish*	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
	N=13	N=27*	N=26*	N=8	N=45	N=5
Introduce New Clients	15.4 (6.8)	11.1 (13.3)	23.1 (4.8)	0	6.7 (1.9)	20 (5.3)
Check-In	61.5 (23.9)	14.8 (4.4)	73.1 (12.0)	62.5 (34.3)	26.7 (23.8)	40 (16.4)
Meeting Set-Up	46.2 (4.7)	33.3 (6.0)	57.7 (7.5)	25 (5.5)	53.8 (7.3)	0
Community Management	53.8 (15.0)	55.6 (29.9)	19.2 (12.2)	25 (14.2)	53.3 (15.3)	40 (1.3)
Group/Community Issues	15.4 (8.0)	7.4 (3.8)	0	25 (8.5)	17.8 (23.8)	20 (31.7)
Community Building	0	3.7 (28.6)	0	37.5 (13.7)	22.2 (37.8)	0
Physical Exercise	0	0	0	0	2.2 (2.8)	0
Relaxation/Training	0	0	0	0	0	20 (25.0)
Treatment Readiness	38.5 (26.8)	14.8 (15.8)	15.4 (8.7)	0	35.6 (33.6)	20 (1.8)
Motivation Building	23.1 (9.6)	33.3 (7.0)	57.7 (10.3)	15 (17.9)	51.1 (13.6)	80 (10.0)
Pull Ups/Sanctions	0	0	0	0	8.9 (7.5)	0
Rewards	7.7 (1.8)	7.4 (5.0)	23.1 (4.9)	50 (8.1)	28.9 (7.1)	20 (1.2)

* - Cell values for each item represent aggregated data across multiple treatment programs at these sites.
† - Percent of Meetings in which each item was used.
‡ - Percent of Actual Treatment Time spent on each item when used.

Results for the use of various cognitive-behavioral treatment components are presented in Table 6.4. Meetings in this sample tended to commonly discuss clients' triggers, attempting to improve their awareness of their thought processes (as many as 80% of the observed meetings in residential treatment at Jackson County and typically at least 22% of meetings in all sites). The proportion of treatment time spent on these topics was somewhat more modest, usually being around 5-15% of the total amount of treatment time, but as high as 35% of the meeting time in outpatient treatment in Jackson County. Relapse prevention, while similar to "trigger analysis", is more focused on

helping clients develop alternative ways of dealing with potentially problematic events and was less commonly (lower proportion of observed meetings) and less extensively (smaller percentage of the treatment time when it occurred) used in all of the sites. This disparity may suggest that these programs increase their focus on developing ways to deal with triggering event, in addition to calling increased attention to them.

Many programs also commonly examined the existing emotional processes of their clients (as many as 65% of observed meetings in outpatient programs at Bakersfield), though the use of this item was considerably lower in Creek County, particularly. Again though, when used the proportion of treatment time devoted to it varied widely, from a high of 20% of the meeting in Bakersfield residential and Creek County, to a low of 2.4% of treatment time in St. Mary Parish. Other cognitive-behavioral items were observed to varying degrees of frequency and duration, depending on the site. For instance, existing and alternative cognitive processes and attitudes/values were relatively common occurrences in treatment activities in several sites, as were discussions of the need to develop alternative (pro-social) activities and goals. Despite being relatively common, in terms of the number of meetings in which they occurred, the amount of treatment time spent on each of these topics was generally short (approximately 5% in many sites). Anger management was relatively rare in these programs, however in Bakersfield, those meetings were it did occur seemed to give the topic a good deal of focus. In general, the use of cognitive-behavioral techniques appears relatively common in these programs' activities, but it appears that they may not spend much time focused on specific issues in this realm. The more general topic of "problem solving/coping skills" was both relatively common (meetings) and extensive (15% of treatment time or more in 4 of the 6 program groups). This result too may suggest that the programs are attempting cognitive-behavioral treatment interventions, but are doing so in a more generic, rather than focused manner.

Some general conclusions can also be reached in regards to the items that were rarely, or briefly covered in many of the sites. For instance, structured social skill training (using a pre-packaged curriculum) was almost never used in any sites. The expense associated with purchasing these, often proprietary materials may account for this pattern. Similarly, several treatment components associated with Rational Emotive Therapy were infrequently and briefly used in most sites (emotion management, disputing, and Self-acceptance). It would appear that while some of these programs are employing cognitive-behavioral treatment strategies, few are employing this specific form of therapy.

Table 6.4 Cognitive – Behavioral Items

Item % of Meetings† (%Time) ‡	*St. Mary Parish*	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
	N=13	N=27*	N=26*	N=8	N=45	N=5
Triggers/Awareness	38.5 (6.8)	40.7 (16.0)	38.5 (11.6)	37.5 (3.2)	22.2 (35.4)	80.0 (9.5)
Relapse Prevention	7.7 (1.0)	14.8 (83.5)	19.2 (14.8)	0	13.3 (100%)	40.0 (70.0)
Anger Management	23.1 (10.1)	11.1 (37.5)	7.7 (51.5)	12.5 (100)	4.4 (20.0)	0
Feelings/Thoughts & Behavior	7.7 (5.1)	22.2 (19.7)	11.5 (4.6)	12.5 (7.5)	11.1 (14.9)	0
Existing Attitudes/Values	38.5 (15.5)	11.1 (15.1)	11.5 (1.9)	12.5 (1.7)	44.4 (6.1)	60.0 (4.7)
Alternative Attitudes/Values	46.1 (6.5)	22.2 (16.5)	19.2 (3.5)	12.5 (3.4)	35.6 (6.1)	40.0 (6.1)
Existing Emotional Processes	46.1 (8.9)	7.4 (19.9)	65.4 (7.6)	62.5 (19.7)	26.7 (7.3)	60.0 (2.4)
Alternative Emotional Processes	7.7 (2.7)	3.7 (3.3)	26.9 (4.1)	62.5 (7.9)	8.9 (5.8)	20.0 (3.7)
Existing Cognitive Processes	23.1 (7.3)	14.8 (12.2)	42.3 (6.0)	50.0 (4.6)	22.2 (5.3)	60.0 (5.2)
Alternative Cognitive Processes	30.8 (8.0)	40.7 (11.5)	42.3 (15.1)	37.5 (3.2)	13.3 (7.4)	60.0 (4.0)
Alternative Activities	23.1 (4.0)	33.3 (8.1)	30.8 (6.9)	25.0 (3.5)	11.1 (7.4)	0
Alternative Goals	0	2.2 (13.9)	23.7 (6.3)	37.5 (2.9)	13.3 (5.8)	40.0 (2.4)
Problem Solving/Coping	38.5 (22.1)	37.0 (54.4)	42.3 (10.3)	37.5 (7.4)	24.4 (22.7)	60.0 (16.0)
Structured Social Skills	0	3.7 (60.0)	0	0	0	0
Emotion Management	0	0	0	12.5 (3.0)	4.4 (2.5)	0
Disputing	0	0	0	0	0	0
Self-Acceptance	0	0	0	25.0 (3.4)	4.4 (2.3)	0

* - Cell values for each item represent aggregated data across multiple treatment programs at these sites.
† - Percent of Meetings in which each item was used.
‡ - Percent of Actual Treatment Time spent on each item when used.

Table 6.5 Education and Aftercare Items

Item % of Meetings† (%Time) ‡	*St. Mary Parish*	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
	N=13	N=27*	N=26*	N=8	N=45	N=5
Clinical Education	30.8 (45.5)	7.4 (18.1)	30.8 (11.7)	12.5 (23.8)	26.7 (22.2)	20 (36.6)
Drug Education	7.7 (2.0)	11.1 (71.6)	46.2 (41.2)	0	8.9 (11.5)	20 (1.8)
Drug Videos	0	11.1 (58.3)	3.8 (61.2)	0	20 (94.2)	0
Academic Education	0	0	0	0	0	0
Vocational Education	0	0	0	0	0	0
Job Skills Training	0	3.7 (84.4)	0	0	0	0
Health Issues	7.7 (3.0)	0	15.4 (30.7)	12.5 (92.6)	2.2 (2.8)	20 (100.0)
Parenting Skills	7.7 (1.0)	7.4 (39.5)	7.7 (54.3)	0	0	0
Homework/Workbooks	7.7 (96.0)	59.3 (58.0)	7.7 (26.8)	0	2.2 (59.4)	0
Relationships/Co-Dependency	23.1 (49.1)	0	7.7 (16.4)	0	4.4 (36.2)	20 (15.9)

* - Cell values for each item represent aggregated data across multiple treatment programs at these sites.
† - Percent of Meetings in which each item was used.
‡ - Percent of Actual Treatment Time spent on each item when used.

Results for the use of education and aftercare items among this sample of programs suggest that they are not focusing a great deal on these issues (see Table 6.5). For example, neither academic nor vocational education activities took place during any of the meetings observed in these sites. Similarly, job skills training was only observed in one site and only in one meeting (though this one meeting was dominated by this activity). On the other hand, clinical education (preparing clients for participation in treatment, by teaching them the vocabulary of a specific treatment approach, for example) was relatively common in these programs, occurring in as many as 30% of meetings in some sites. The frequency of these clinical education activities varied by site, as did the amount of time devoted to the activity, when it was employed (anywhere from 20% to 45% of meeting time). Drug education (e.g., providing information about the impact of various drugs) also occurred in most of the programs observed (except the residential program in Bakersfield). Again, the incidence of this activity and its duration when used, varied by site. Outpatient programs in Bakersfield in particular seemed to rely heavily on drug education, both in terms of the percent of meetings in which it was covered and in terms of the amount of time devoted to it within those meetings. Drug education videos, though used somewhat sparingly (only in relatively small numbers of meetings in Creek County, and outpatient programs in sites 1 and 4) in these programs, dominated treatment meeting time when they were used (60% to 95% of the meeting). Reviewing homework or workbook assignments were used very infrequently except in Creek County, where they appeared to make up the majority of treatment activities, both in terms of frequency and amount of time devoted to them.

Health issues (e.g., information on sexually transmitted diseases, nutrition and meal planning) also seemed to be covered to varying degrees in most of these sites, with the exception of Creek County. There was relatively wide variation here as well, in terms of both frequency and average amount of time devoted to health issues. Unfortunately, parenting skills training appeared to be relatively rare, occurring in only 3 program groups (sites 2, 3, and outpatient programs in Bakersfield). Even within these programs where this activity was observed the frequency of its occurrence was extremely low (about 7% of meetings in these 3 program groups), though the amount of treatment time devoted to it did appear to be extensive (between 40% and 50% of the meeting) in two of these.

Issues such as gender expectations and relationships/co-dependency were also generally addressed sparingly among these programs, with St. Mary Parish being the major exception (about 20% of meetings dealt with these issues to some degree). Issues of cultural diversity were almost never addressed in these programs, occurring only in Jackson County. Even in this site, the examination of cultural diversity issues was uncommon in the outpatient programs, and was not given much attention in the 20% of meetings in which they occurred in the residential programs. In general it appears the programs would benefit from improving the cultural sensitivity of their interventions, especially in light of the fact that several of the sites serve substantial minority populations. Interestingly, Jackson County, which at least attempted to deal with cultural issues, had the largest proportion of African American clients participating in groups. It is difficult, due to the low counselor response rate in some sites, to accurately estimate the proportion of minority counselors in each site, but culturally sensitive treatment may be facilitated by the use of a more diverse group of counselors.

Finally, in terms of preparing clients for eventual program graduation by discussing issues related to aftercare treatment or other needed social services, this group of programs appeared to fall short of an ideal level of preparation. In general, when a few of these sites did provide for the discussion of aftercare issues, this took place in less than 10% of the observed meetings, and was only briefly discussed in those few meetings (again less than 10% of the actual treatment meeting time).

Table 6.6 Safety and Self-Exploration Items

Item % of Meetings† (%Time) ‡	*St. Mary Parish*	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
	N=13	N=27*	N=26*	N=8	N=45	N=5
Self-Esteem/Efficacy	15.4 (6.6)	7.4 (7.1)	11.5 (36.3)	25.0 (6.9)	6.7 (38.0)	60.0 (5.8)
Healing/Nurturing	0	0	3.8 (3.8)	12.5 (6.9)	0	0
Family Issues	38.5 (8.4)	22.2 (6.5)	50.0 (9.3)	25.0 (20.9)	6.7 (3.1)	40.0 (3.0)
Experiences on the Street	38.5 (21.8)	33.3 (11.1)	38.5 (5.5)	12.5 (1.8)	28.9 (10.5)	40.0 (4.3)
Other Life Experiences	30.8 (4.4)	29.6 (6.2)	36.9 (8.9)	12.5 (2.2)	6.7 (16.3)	0
Recent Incidences	61.5 (8.1)	44.4 (16.5)	69.2 (8.4)	75.0 (20.5)	35.6 (37.5)	60.0 (14.3)
Diaries/Journals	7.7 (31.4)	7.4 (14.5)	0	12.5 (23.8)	0	0
Letters	7.7 (19.6)	0	3.8 (50.8)	25.0 (6.5)	0	20.0 (12.3)
Defense Mechanisms	23.1 (15.6)	7.4 (2.3)	38.5 (5.0)	0	22.2 (14.0)	60.0 (7.0)
Physical Safety	7.7 (23.8)	0	3.8 (2.8)	0	2.2 (1.2)	0
Psychological Safety	7.7 (7.5)	0	15.4 (29.0)	12.5 (1.8)	4.4 (1.8)	0
Counselor Shares Experiences	23.1 (3.9)	25.9 (4.8)	42.3 (7.3)	37.5 (21.0)	33.3 (8.2)	20.0 (5.3)

* - Cell values for each item represent aggregated data across multiple treatment programs at these sites.
† - Percent of Meetings in which each item was used.
‡ - Percent of Actual Treatment Time spent on each item when used.

This group of programs appeared to provide more extensive opportunities for clients' self-exploration and development of feelings of safety within the group context (see Table 6.6). Among the more commonly employed activities in this area was the discussion of recent incidents (in at least 35% of meetings) as a means of facilitating client self-exploration, as well as the counselors' sharing of their own perspectives on treatment-related topics (in at least 20% of meetings observed in all sites). While relatively common in their occurrence, both of these activities tended to be brief in duration, accounting for between 5 and 20% of the meeting time. This would suggest that meetings were not just "rap sessions" in which clients and counselors merely discussed current events, but more likely that they used these areas as ways to draw parallels between more abstract treatment concepts and real-life occurrences. Family issues occurred in some sites in large proportions of observed meetings (50% of meetings in Bakersfield outpatient programs), but were generally briefly covered (about 5% to 10% of actual treatment time in most sites).

Experiences on the street and the review of other sorts of life experiences were also relatively common, occurring in moderate numbers of meetings in all sites, though again, usually only for brief periods of time. Coupled with results showing that issues of self-esteem and self-efficacy were common across these sites, the results for reviewing

past life experiences would suggest that these programs were relatively focused on improving client's ability for introspection. Similarly, all but the residential program in Bakersfield used examination of client defense mechanisms to some degree, further supporting the idea that the programs attempted to get clients to look at themselves in some detail. These results also fit with the relatively common use of trigger analysis described in the Cognitive-Behavioral Treatment items section above. Clients' comfort level with this introspection would likely be further improved if the programs were more consistent in their attempts to develop the clients' sense of physical and psychological safety within the treatment context, as these issues appeared to be somewhat underutilized. Similarly, the use of formal techniques to foster self-exploration, such as having clients keep and review journals or diaries could be more thoroughly employed than they were in these programs.

Table 6.7 12-Steps (AA/NA) and Therapeutic Community (TC) Items

Item % of Meetings† (%Time) ‡	*St. Mary Parish*	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
	N=13	N=27*	N=26*	N=8	N=45	N=5
Acceptance of Powerlessness	23.1 (1.7)	3.7 (7.1)	19.2 (4.3)	0	11.1 (8.4)	60.0 (12.2)
Spirituality/Higher Power	7.7 (6.3)	18.5 (3.0)	11.5 (5.1)	25.0 (3.4)	60.0 (3.5)	22.2 (7.5)
Moral Inventory	7.7 (1.3)	3.7 (7.5)	0	12.5 (8.3)	20.0 (1.2)	4.4 (5.4)
Making Amends	0	0	3.8 (1.1)	12.5 (53.3)	40.0 (2.4)	11.1 (30.0)
Other AA Traditions	0	11.1 (8.2)	19.2 (6.8)	50.0 (14.3)	40.0 (6.7)	35.6 (13.0)

* - Cell values for each item represent aggregated data across multiple treatment programs at these sites.
† - Percent of Meetings in which each item was used.
‡ - Percent of Actual Treatment Time spent on each item when used.

According to the results presented in Table 6.7, the degree to which this sample of drug court programs employed treatment components characteristic of 12-steps programs varied by site. In general, however some of these issues did appear in all of the programs observed. Several programs included discussion of the need to accept ones' powerlessness over addiction, the reliance on a higher power, and Alcoholics Anonymous "traditions" of "making amends" and taking a "moral inventory", though in general these issues were not dealt with for long periods of time (usually about 5% of the actual treatment time). Thus, despite the common use of cognitive-behavioral treatment techniques, the influence of the 12-steps/disease-model continues to permeate these programs, if only in the form of brief mentions or reminders of these concepts. To some extent this is not unexpected given the results from the counselor's survey on philosophy of effective treatment, which demonstrated an eclectic approach to treatment among this sample of counselors.

The use of confrontation in dealing with inappropriate thoughts, statements or behaviors is a common component of therapeutic community programs (many of which typically adopt a 12-step/self-help style of treatment). The use of confrontation varied within these programs, but did occur to some extent in every site, and was usually more likely to have originated from the counselors than other clients. However, when confrontation did occur it tended to be relatively brief, suggesting that the inappropriate behavior was pointed out and the group likely then proceeded to other business. Creek County seemed to be particularly unlikely to use confrontation either by counselors or clients. This may be related to the fact that the programs in Creek County predominately focused on clients reviewing their workbook assignments, rather than participating in treatment groups characterized by more clinical interaction.

Summary

Results from the observation of treatment activities themselves suggest that the treatment programs involved with these four drug courts are implementing drug treatment interventions characterized by a broad range of therapeutic approaches. In general, the observational results reveal a pattern of mixed approaches, including cognitive-behavioral techniques, like trigger analysis and examination of existing emotional processes, coupled to a lesser extent with techniques derived from 12-steps programs (acceptance of powerlessness, reliance on a higher power). In addition, staff survey results (presented in Chapter 5) indicate that this group of counselors, as a whole, tended to endorse an approach to substance abuse treatment that is amalgamated in nature, employing multiple, sometimes conflicting approaches concurrently with little in-depth focus on any particular therapeutic issue.

While this approach to substance abuse treatment may sound like an effective intervention style, potentially addressing multiple client needs, this set of results also suggests that the actual impact of this style among these programs was that they spent relatively small amounts of time on any specific treatment item. For instance, the programs tended to spend relatively larger amounts of time on increasing client's awareness of possible triggers, but at least partly because they were also attempting several other treatment approaches, they did not appear to adequately provide information on what to do with the knowledge of triggers (i.e., much less emphasis on "relapse prevention").

In addition to impeding the delivery of other effective treatment items, the this approach to treatment leads to the delivery of sometimes-inconsistent messages to clients. For instance, the 12-steps approach to substance abuse treatment advocates that clients recognize they are powerless to control their addiction and must turn their lives over to a higher power to help them maintain abstinence. On the other hand, cognitive-behavioral (CBT) approaches to drug treatment require the client to recognize the role that his or her thoughts and emotions play in perpetuating the addictive behavior and to take control of those internal processes by examining them and learning new social, emotional, and cognitive skills. The contemporaneous use of these two approaches (CBT and 12-steps) work against one another in terms of their underlying views of the origins of substance

abuse. Similarly, delivering only superficial treatment from the CBT perspective likely undermines the effectiveness of these approaches that much previous research has demonstrated.

As previously mentioned, programs which address multiple client needs are in fact preferred, in that they may be more likely effective in reducing substance abuse and criminal behavior, however this does not mean that treatment approaches based on incompatible philosophical positions should be forced together. In general these programs are more likely to deliver effective treatment if they coordinate a coherent treatment approach that can tackle multiple client needs. In general, the treatment literature suggests that cognitive-behavioral approaches are effective for offender populations. As such, the programs may benefit from solidifying their use of these types of techniques.

Similarly and despite the reports of the program administrators themselves, very little family counseling was observed during this evaluation period. While some of the group treatment activities observed did specifically deal with "family" issues among the clients themselves, few if any sessions involving the use of family members were observed to have taken place during the site visits. The enlisting of family members in the continued clean living of these clients might be an especially useful adjunct, particularly because most of the clients in these drug courts lived in the community during their treatment.

Finally, none of the programs appeared to provide much in the way of gender or culturally specific programming, as evidenced in the low frequency with which raters observed these topics being discussed in treatment groups. Again, the provision of the specially tailored services may be expected to improve the efficacy of treatment for these specific sub-groups of clients. While white and male clients tended to dominate the proportion of groups in most sites, there were still substantial minority and female populations in each jurisdiction, who may benefit from services specifically tailored to their unique set of needs

Chapter 7

The Integration of Court Operations and Treatment Services

Overview

Drug Courts, boot camps, intensive supervision programs, day reporting centers, jail and prisons have all tried in recent years to incorporate drug treatment into their menu of services for offenders. Many of these programs have failed because of the inability to provide sufficient treatment to effect behavior change within the context of the criminal justice system (Farabee, Prendergast, Cartier, Wexler, Knight, and Anglin, 1999; Latessa & Holsinger, 1999). The difficulties associated with the provision of drug treatment services are often compounded by more general concerns, such as the perception that substance abusing offenders are not motivated enough for treatment (Farabee, et al., 1999) or that treatment is an opportunity that offenders do not deserve (Duffee and Carlson, 1996; Taxman, 1998).

In fact, the treatment delivery system for offender populations is as crucial an issue as the offender's level of motivation to participate in substance abuse treatment services. Both researchers and practitioners tend to focus on the role the offender plays in successful treatment, rather than examine the impact of service delivery itself. Critics frequently cite the fact that offenders do not take advantage of available services or that offenders are prone to quit treatment, resulting in inadequate treatment duration. Others cite the failure of offenders to attend treatment activities, continued use of illicit substances while in treatment, and non-compliance with court-ordered conditions of release (Petersilia, 1999; Taxman, Soule, and Gelb, 1999).

Scholars have also noted that the delivery system itself often fails offenders by using ineffective intervention strategies, such as psycho-education and self-help services (Sherman, Gottfredson, MacKenzie, Eck, Reuter, and Bushway, 1997; Simpson, Joe, Fletcher, Hubbard, and Anglin, 1999; Taxman and Piquero, 1997; Taxman, 1999). As another example of the delivery of poor treatment services, offenders are frequently given standard treatment plans that are not tailored to the needs of the individual. Similarly, few programs provide sufficient opportunity to build the client's motivation for change or to prepare the offender before entering the treatment process (Simpson et al, 1997). Each of these issues— treatment access, treatment content, and client retention—are often perceived as an outcome of poor client motivation, when in fact these are often the result of structural and organizational factors that impede the client's involvement in effective drug treatment services. Few studies have examined how treatment delivery itself interferes with the offender benefiting from participation in treatment services (Wexler, Falkin, and Lipton & Rosenblum, 1992; Taxman, 1998).

Farabee and his colleagues (1999) identified six common barriers to effective treatment for the offender including client identification, assessment, and referral; recruitment and training of treatment staff; redeployment of correctional staff; over-

reliance on institutional versus therapeutic sanctions; aftercare and the use of coercion in treatment delivery systems. These barriers are especially pertinent to "behind the wall" programs, but they also affect community-based treatment programs.

Several of these barriers to effective treatment are particularly relevant to the need to develop "boundaryless" systems of care that join public health and criminal justice agencies in the pursuit of recidivism reduction. For example, a typical problem is that many offenders have too little time in prison/jail to benefit from the full duration of a treatment program. Another important issue is the fact that program eligibility criteria are often ambiguous, making it difficult to identify the characteristics of offenders who will likely benefit from the treatment program. Farabee and colleagues' concerns regarding treatment staff refer to whether the staff are employed by a correctional or health agency and the degree to which the treatment staff are skilled at addressing the clinical needs of the offender, who often has some criminogenic traits that need clinical attention. Treatment programs require special correctional staff, the provision of which often places more demands on a correctional institution to ensure that the security staff is compatible with the treatment program. Aftercare is frequently desired, but seldom materializes because it requires crossing organizational boundaries to link offenders to treatment services in the community.

The Importance of Service Delivery Systems

In recent years, several attempts have been made to incorporate treatment within the criminal justice system in a manner that moves away from the traditional emphasis on coordination and collaboration as an operational framework. Instead, these integrated service models are based on the concept of "boundaryless" organizations. Boundaryless organizations are characterized by shared inter-agency goals and operational practices at key decision points that are common to both criminal justice and treatment agencies. This approach emphasizes the creation of policies and operational practices that transcend agency boundaries, overcome "bureaucratic turf issues", and develop processes that benefit the individual agencies.

The concept of a boundaryless organization evolves from organizational-system perspective focused on creating integrated processes that contribute to desired outcomes, rather than focusing on the performance of parts of the system. As noted by Hammer (1996):

> The problems that afflict modern organizations are not task problems. They are process problems. The reason we are slow to deliver results is not that personnel are performing individual tasks slowly and efficiently; fifty years of time-and-motion studies and automation have seen to that. We are slow because some of our personnel are performing tasks that need not be done at all to achieve the desired result and because we encounter agonizing delays in getting the work from the person who does one task to the person who does the next one…We are inflexible not because individuals are locked into fixed ways of operating, but because no one has an understanding of how individual tasks combine to create a result, an understanding absolutely necessary for changing how the results are created (pg. 5-6).

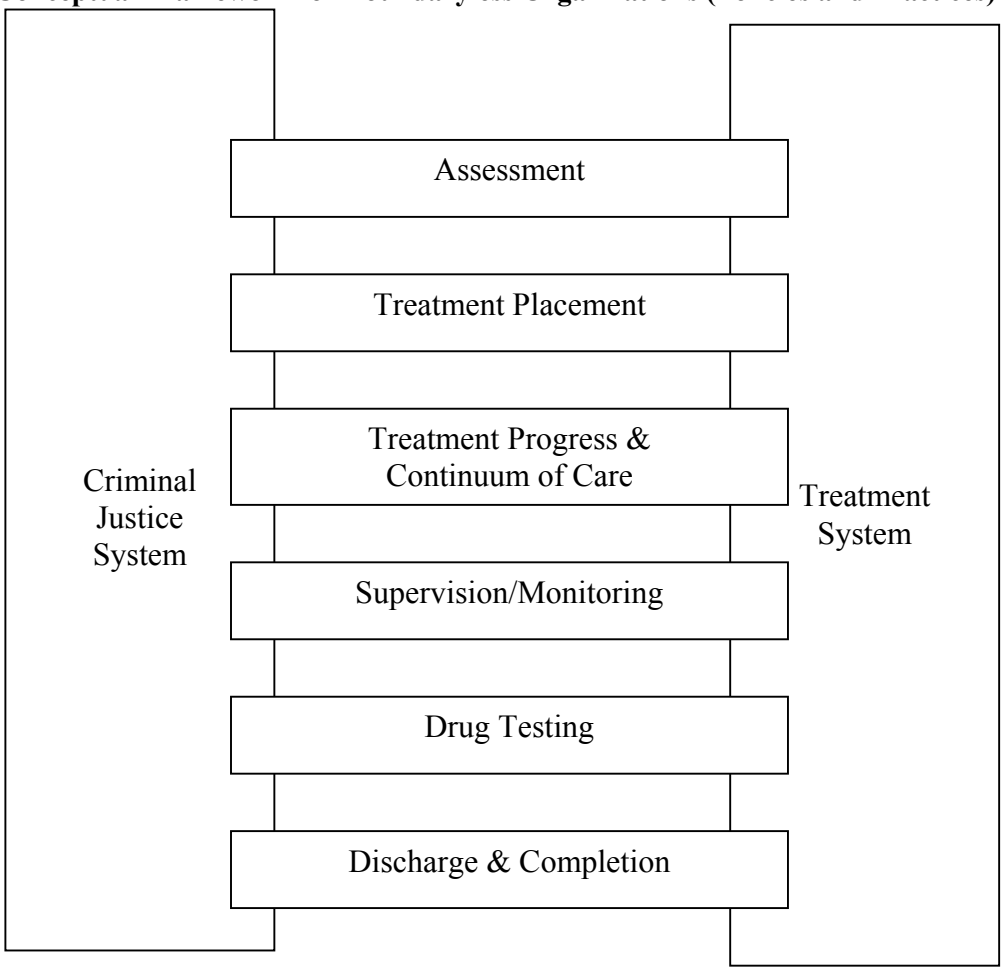
Figure 7.1 illustrates how these boundaryless processes must occur in order to allow the criminal justice and treatment systems to work together on key decision points.

The implementation of both treatment and correctional services will be streamlined by the coordination of these systems in regards to these key decision points. In their work with private sector companies, Askenos, Ulrich, Jick, and Kerr (1995) have shown that the creation of boundaryless (i.e. seamless) organizations requires a new focus, allowing processes to function far better as a whole than do their separate parts. Within this framework the roles and responsibilities of each organization remain consistent with their original goals, but they also work in concert with the other agencies' inputs. In fact, Askenos, et al (1995) suggests that:

> …there are still leaders who have authority and accountability, there are still people with special functional skills, there are still distinctions between customers and suppliers, and work continues to be done in different places (pg. 4).

By focusing each organization on the overall process and not simply on their own goals and responsibilities, services can be implemented in a manner that maximizes their overall efficiency and effectiveness.

Figure 7.1
Conceptual Framework for Boundaryless Organizations (Policies and Practices)



Moore (1991) in his discussion of integrated services has suggested that each agency would participate in key decisions regarding the client, including placement in appropriate services, modification of treatment plans based upon client progress, the

transition to other services when deemed appropriate and eventual discharge from the system. Rather than mere coordination of services and efforts around these issues there would be an integration and synthesis of agencies' policies and operational practices. Within the systems approach to service delivery the initial focus must be on building the infrastructure needed to support the functions of each agency. In order to accomplish this, policy development must focus on such issues as client assessment, referral, placement, tracking and monitoring, service planning, transition through services, and eventual discharge. In terms of the criminal justice/treatment system, such boundary spanning activities, especially as related to the initial development of integrated policies appears to be an essential next step in the evolution of effective treatment delivery systems.

As an example of an attempt to create a “boundaryless” service delivery system, the Washington-Baltimore High Intensity Drug Trafficking Area (HIDTA) project has implemented an integrated criminal justice/treatment system of services (Taxman and Lockwood, 1996). A five-year long process evaluation of this seamless system is underway and early results suggest that this is a promising approach for the delivery of effective drug treatment services to criminal justice clients. For example, preliminary data suggest a significant reduction in the rearrest rates for offenders involved in the process compared to those involved in a traditional service delivery model (Taxman and Cronin, 2000). This integrated system of service delivery is characterized by several distinct core components, including client focused policies, delivery systems based on a continuum of care, and the use of coerced treatment, behavioral contracts, and graduated sanctions with clients, as well as the prioritization of system resources. Each of these core components is implemented with the cooperation of both criminal justice and relevant public health agencies.

This systemic approach to service delivery is designed to combine the roles and functions of different organizations, such as public health, criminal justice, social services, mental health and other relevant agencies. In so doing, the seamless system approach expands the organizational boundaries of these participating agencies. In the traditional service delivery model these two entities would likely try to "coordinate" fragmented services, typically struggling over which agency ultimately "controls" the decision-making regarding the client. In a systems or seamless organizational approach, participating agencies would initially agree upon certain guiding principles of care then determine the appropriate roles and functions for each player in delivering that level of care. From this organizational perspective the emphasis is then on the effective operation of the system itself and its complementary parts, rather than on the role of any one agency.

Are Drug Courts Boundaryless Organizations?

By design drug court programs appear to be the epitome of “boundaryless” organizations, but the extent to which this sort of integration has been achieved is largely unevaluated. Drug courts are compulsory, court-ordered substance abuse treatment programs that attempt to incorporate two competing perspectives on the causes of substance abuse and addiction, specifically the criminal justice and medical models. The

criminal justice model conceptualizes drug addiction as one of many antisocial behaviors manifested by criminals, while the medical model conceptualizes addiction as a chronic and relapsing disease. Consistent with these differing conceptualizations of addictions, the courts and treatment community also tend to use differing types of interventions to respond to addictions (and associated criminal behaviors). Traditionally, courts have employed legal sanctions, such as incarceration or probation sentences. Partly, these responses arise out of a concern for public safety, as well as an attempt to change the substance abusing/criminal behavior through deterrence and/or incapacitation. On the other hand, the treatment community tends to emphasize therapeutic relationships and the use of treatment services (e.g., awareness and new skills building) as means of changing behavior and reducing substance abuse. Operating from differing theoretical perspectives and employment of vastly different types of behavior change techniques, the courts and treatment community have not always worked well together traditionally. As an example, Nolan (1998) claims:

> …The relationships between these organizations are often strained by philosophical differences between the traditional adjudicative perspective of the courts expecting external supervision and probation like-monitoring and the therapeutic orientation of the treatment provider seeking to increase interpersonal skills of clients based upon the identification of their treatment needs to prevent relapse (Nolan, 1998:110-112).

Prior to the development of drug courts as a response to the problem of drug abuse and crime, these philosophical and operational differences resulted in treatment and criminal justice personnel working within their own autonomous domains. This arrangement resulted in little cooperation and integration of efforts between these parties. In fact, the closest approximation of cooperation occurred only when courts "sent" offenders to treatment, seemingly with little interest or knowledge of what might actually take place there. As Goldkamp (1998: 170) points out:

> At the heart of the treatment drug court is a newly negotiated working relationship between treatment providers and the criminal court. The drug court does not simply refer cases out to treatment, as in the traditional probation model. Rather, partly out of dissatisfaction with how the probation model has worked, the drug court works out a regimen or range of treatment services that will be provided during the period the court has the defendant or offender under its control. As the drug court model has evolved this has also meant involvement of related health and social services (such as education, employment, housing, etc.) to strengthen the treatment process and to build strong links to the community and aftercare. Thus, in the drug court, the criminal court has been challenging the substance abuse treatment profession to create a treatment approach that can be effective within criminal justice boundaries, all while linked more accountably to the criminal court judge.

While the development of the drug court model has been predicated on the integration of treatment services and court operations, the concept of integration in this context has not been fully elucidated thus far. The idea of integrating treatment services into the traditional criminal justice system is innovative and potentially more effective than the traditional arrangement. However, little thought seems to have been given so far to what "integration" means in drug courts. Further, there have been few attempts to define exactly what this integration of services should look like, other than general statements such as *"Drug courts integrate alcohol and other drug treatment services with justice system case processing"* (DCPO, 2000). Similarly, researchers have largely ignored the implementation and effectiveness of varying types and levels of integration.

It stands to reason that the degree of integration between treatment and court operations can affect the success of a drug court program, particularly in terms of the overall ability to deliver effective services that will reduce both substance abuse and criminal involvement (and maybe increase other desirable behaviors such as family, educational or employment participation).

Anecdotal accounts from various drug court personnel indicate that the relationships between treatment and criminal justice personnel are often imbued with difficulties. As noted above, treatment and criminal justice organizations represent vastly different cultures and ideologies. There are potential conflicts over the purposes and goals of each party's activities and there are often competing differences in the preferred means employed to achieve these goals. Inability to resolve these conflicts can interfere with the cooperation that is intended to be a central component of the drug court model. Writing about this specific issue and how the drug court model can address it, Goldkamp (1998:170) suggests:

> …these conflicts have to be resolved in a working relationship that is new and comprehensive, and which integrates values and features of the respective disciplines in an operating framework acceptable to the criminal court.

The drug court model differs from prior efforts to deliver drug treatment to offenders with substance abuse problems because court and treatment operations are specifically intended to be integrated (however that is defined), both in the development and implementation of each set of services.

Taxman and Bouffard (2001) have written about the integration of criminal justice and treatment services in other settings, specifically about the need to integrate these services at several levels. For instance, services need to be coordinated or integrated in terms of several different decision points, such as assessment, treatment placement, movement through treatment phases, program graduation, response to misbehavior (e.g., imposition of graduated sanctions), and drug testing procedures. In addition, integration or coordination must take place at the level of policy development, development and management of funding sources, and various other operational and administrative responsibilities, such as record keeping and information sharing. Examples of some of these areas are more fully presented below.

a. <u>Philosophical Integration</u>

   Do drug court administrators and staff share a similar view of the causes and appropriate responses to substance abuse and criminal behavior as those held by treatment program administrators and staff?

b. <u>Policy Development & Funding Integration</u>

   Do directors of each agency (and their superiors), as well as those who make funding decisions work together to develop integrated policies and share financial responsibilities for the operation and continuation of the program? Is there a steering committee composed of members of various relevant treatment, criminal justice and community agencies?

c. Operational-level Decision-Making/Information Sharing Integration

Do line staff within each agency routinely work together to make decisions regarding the handling (e.g., screening, placement, imposition of sanctions) of individual cases? Are there institutionalized policies and procedures in place to support this integration and cooperation among line staff in case planning? For instance, are there regularly scheduled treatment planning meetings involving both staff? Are there procedures in place for the sharing of assessment/re-assessment, drug testing or treatment progress information?

d. Cross-Program Familiarity Issues

Do members of each programs' (court versus treatment) staff have a working familiarity with the goals and relevant procedures employed by their counterparts? Do staff members share similar goals and are they able and willing to work together to achieve these shared goals?

The importance of integrating treatment operations with court operations is underlined in the first Key Component of drug courts[9]. To the extent that this integration of services is the central tenet of the drug court model, the most important issue affecting drug court program operations and success centers on the effective collaboration and communication between both treatment and criminal justice personnel.

Drug courts are intended to incorporate treatment principles within a structured environment for monitoring the progress of the offender using state-of-the-art technology including scientific needs assessment, appropriate treatment placement, frequent drug testing, and graduated sanctions. In essence, drug courts integrate aspects of the treatment and criminal justice system to form a unique service delivery system. Combining the coercive power of the court with what is hopefully effective and scientifically based treatment practices; these programs jointly promote abstinence and pro-social behavior, through an integrated set of criminal justice and treatment services. (Belenko, 1998; NDCIR, p6).

Although the integration between treatment providers and court operations is a *Key Component* of drug courts and the literature clearly indicates that communication between substance abuse treatment staff and criminal justice staff are critical to the success of the program, there is a paucity of research attempting to demonstrate the extent to which integration has been achieved. One of the goals of the current evaluation then is to explore the process of examining integration at various levels within these drug courts, as well as to explore the types of data collection techniques that might be used to address these issues.

[9] Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing.

Methods and Sources of Information

As we have seen, defining the term integration remains problematic in itself. A review of the literature reveals several meanings to integration in the drug court context. Several sources were consulted to begin to synthesize our thinking about the concept of integration within the drug court context. The first source is a recent NIDA CJ-DATS Request for Proposals. The RFP continues the emphasis upon goals of collaboration and communication as important ingredients of integration. A second source of information regarding the issue of integrated services is the Drug Court Planning Office who identified a series of "benchmarks" for each of the *Ten Key Components of Drug Courts.* Although these benchmarks are targeted at practitioners, for use as a guide to developing drug court programs that are faithful to the original model, they are also helpful in operationalizing a definition of "integrated" services.

This research utilized several different approaches to garner useful information to explore the level and types of integration occurring within the four drug courts programs. First, we examined drug court policy statements contained in official documents. It is likely that an examination of existing policies "on the books" will provide some information about how well the programs were at least intended to be integrated. Our evaluation illustrates integration of policy in terms of the phasing system.

The second source of information about integration involves interviews with criminal justice personnel. These interviews allowed us to explore some of the issues surrounding different levels of integration such as court staff views about the relationship between crime and substance abuse and the role the court plays in the treatment process.

A third source of information involves the use of surveys of counselors providing treatment services (see chapter 2). These surveys were used to collect information directly from those involved in the development and day-to-day operation of the court programs. Specific topics included first hand information about the operation of court/treatment services, at various decision points, such as screening, assessment, treatment placement, enforcement of graduated sanctions, and program graduation. More integrated programs would likely have more collaboration on each of these issues, with both treatment and court personnel having regular and formalized input into these key decision areas.

Fourth, we examined how court and treatment organizations maintained communications with one another. The collaboration and communication between treatment and court personnel was recently identified by NIDA as an important dimension of integration in the drug court context. Several questions in our interview schedules for both treatment and court personnel examined relationships between treatment and criminal justice staff and the extent that collaboration and communication occurred between treatment and court organizations[10]. These questions allow us to examine the level of criminal justice involvement in treatment and conversely, the level of treatment involvement in criminal justice operations.

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[10] The recent NIDA request for applications for CJ-DATS (2002) refers to "An Integrated Systems Approach" that includes "collaboration and communication between drug treatment and criminal justice staff" as components.

The final source of information about integration was obtained from observations of drug court staffings and court status hearings. These direct observations of the court's hearings were used to assess the degree of integration and cooperation within the courtroom itself. Staffings and court room sessions were attended by one team member during the site visit. The purpose of this observation was to document the extent that team decisions about drug court participants during staffings were reflected in courtroom decisions by the judge.

Integration According to Court Personnel

Interviews with court personnel provide one way to assess the level of integration between court and treatment in the drug court context. Criminal justice staff were questioned about the role substance abuse plays in crime, the priority that substance abuse treatment occupies in the program, communications about participants in pre-court staffings, the extent that information is shared across program components, and the typical problems encountered in working with treatment personnel. Their responses are organized around the various levels of integration discussed above.

Philosophical Integration

One indicator of philosophical integration is the extent that court staff have views about the relationship between substance abuse and crime that are compatible with the goals of substance abuse treatment. Overall, court staff appear to believe that substance abuse and crime are highly related – though not necessarily causally so. Most believed that substance abuse issues occur first and that criminal activity follows. Here are some of the responses from judges, prosecutors, sheriffs, and police to the question: How are substance abuse and crime related –if at all?

> Many people come to crime through drugs. It's environmental. Many crimes are caused by drug use.
>
> Substance abuse and crime are both highly correlated with poverty.
>
> I think substance abuse is a social problem, not a criminal problem. I would support substance abuse being a mental health problem. I don't know what causes people to steal but if you solve the drug problem, it will solve the crime problem in 85% of the cases.
>
> Substance abuse is caused by people being unable to solve problems encountered in life and this seems to be a way of escaping. Crime seems to be related to lack of education and having a job.
>
> Substance abuse is caused by environmental factors. Environmental factors like upbringing and emotional pain and child abuse. Crime is caused by lack of self discipline and morals.
>
> It's a chicken and egg problem. Substance abuse is family generated, culture generated, poverty generated and peer generated.
>
> The source of crime is as old as humanity- poverty and lack of education. I do not know the causes of substance abuse We could get into peer pressure to use, good and evil….

> Illegal drugs are expensive. People commit crimes to buy drugs – women sell themselves. There is a strong correlation with poverty as well as physical and sexual abuse, and there is a genetic tendency toward addiction.

Moreover, court personnel believe that the delivery of substance abuse treatment services is the primary goal of their drug court program.

> We focus on treatment. Other requirements are second.
>
> Yes, people sometimes go to jail for missing treatment.
>
> Treatment is really the core component. Clients do not get to write their own program.
>
> Treatment is the primary goal of the program.

In addition, court personnel believe that coerced treatment is effective and believe their role is to ensure participants are in compliance with the performance expectations of drug court and treatment programs. Moreover, court personnel do not believe that most of the participants in their drug court program would succeed with only a substance abuse treatment program. They believe that many drug court participants need the leverage and structure provided by the drug court. Here are some of their comments:

> Treatment by itself is no more effective than probation by itself.
>
> Four out of ten fail the drug court program but 80% of the probationers fail probation.
>
> Some would succeed. There are various levels of addiction. Going to treatment will resolve their problem, for others, even our intervention is not going to help. A significant portion got pretty lousy parenting, the court acts as parents holding them responsible.
>
> They would not be as successful. Our group (drug court) is better than anywhere else. This is Mayberry. We know everybody.
>
> No, they would not. It fails to understand that treatment and criminal justice are in conflict. There are clashes with treatment I can't pretend crimes don't happen.
>
> That's been proven by NIDA. It works because coerced treatment works. You do not have to wait till they hit bottom.
>
> In a way, yes and no. There is a need for judicial review but not every two weeks but every six weeks given the community sentence structure which has built in supervision.
>
> Some would and others would not – it depends on the level of addiction.
>
> No, the judge is an authority figure. Just treatment has been available.
>
> About 40% would succeed with treatment. In our court, a lot of people go to drug court and don't need to.
>
> Oh no. The rare person might. These people have poor jobs, education. Life happens. It is never their fault.
>
> No way, I've been there. Treatment was no more effective than probation: 60-70% of the people in drug court are a success because they have no contact with the criminal justice system after graduation.

Policy Development Integration

One important drug court policy indicative of the level of integration between court and treatment operations is the phase system. Outpatient treatment is typically delivered as a step-down program in several phases consisting of specific requirements for participants. Nationally, not all drug courts deliver their program in phases. When they do have a phase system, there may be a single set of requirements from treatment or the courts that participants are expected to complete or separate sets of requirements for treatment and drug court programs.

The extent that both court requirements and treatment requirements are incorporated into the phase system is one indicator of integration because it represents the end result of collaboration between treatment and court personnel at the level of policy. We assessed the content of phases as described in the Policies and Procedures Manuals of each drug court and described those phases in Chapter 4. Here we are concerned with the articulation and identification of specific court and treatment requirements in the policies that govern the operation of the drug court.

Since the four drug courts provide a step-down phased system of requirements, it is possible to identify separate components of drug court requirements and substance abuse treatment requirements for each program phase. As shown in Table 7.1 (next page), we were able to identify both specific court and treatment requirements expected of participants from a review of the Policy and Procedures Manuals. Participants at each site are expected to comply with requirements from both treatment and the courts reflecting a level of co-ordination in providing clients clear information and in implementing an integrated phasing system. Overall, the number and content of requirements expected of participants varies by site.

Table 7.1 Cross-Site Comparisons of Phase System Requirements

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Phase 1				
Develop and Initiate Treatment Plan	•	•	•	•
Psychosocial and Physical Assessments	•	•		
Attend Treatment as Required	•	•	•	•
Attend Drug Court as Required	•	•	•	•
Report to Case Management as Required	•	•	•	•
Engage Significant Others in Recovery Process				•
Drug Testing as Required	•	•	•	•
Attend AA/NA	•		•	•
Obtain AA/NA Sponsor	•			
Assess Job Skills/Education	•			
Obtain Stable Housing		•		
Obtain Employment, Training or Education		•		•
No New Criminal Charges	•	•	•	•
Pay Court Costs/Fees		•		
Minimum Sobriety Requirement	Unspecified	45 days	Unspecified	30 days
Phase 2				
Develop Recovery Plan	•			
Attend Treatment as Required	•	•	•	•
Attend Drug Court as Required	•	•	•	•
Report to Case Management as Required	•	•	•	•
Drug Testing as Required	•	•	•	•
Engage Significant Others in Recovery Process				•
Attend AA/NA	•		•	•
Obtain/Maintain AA/NA Sponsor	•			
Assess Job Skills/Education	•		•	
Obtain Stable Housing		•		
Obtain Employment, Training or Education	•	•		•
Complete Community Service				•
No New Criminal Charges	•	•	•	•
Minimum Sobriety Requirement	60 days	60 days	Unspecified	90 days
Pay Court Costs/Fees		•	•	
Phase 3				
Update Recovery Plan	•			•
Attend Treatment as Required	•	•	•	•
Attend Drug Court as Required	•	•	•	•
Report to Case Management as Required	•	•	•	•
Drug Testing as Required	•	•	•	•
Engage Significant Others in Recovery Process	•		•	•
Attend AA/NA	•		•	•
Obtain/Maintain AA/NA Sponsor	•			
Obtain Stable Housing				
Obtain Employment, Training or Education	•	•	•	•
Complete Community Service				•
No New Criminal Charges	•	•	•	•
Resolution of All Outstanding Warrants				•
Minimum Sobriety Requirement	2 months	4 months	Unspecified	6 months
Pay Court Costs/Fees		•		•

Operational-level Decision Making/Information Sharing

One of the key decision points in the drug court context centers on how people are admitted to the program. Prior to drug courts, the courts (or their designated agency such as probation) referred offenders to treatment. Ideally, in the drug court model, the decision about who is admitted to the program is a collaborative one.

In Chapter 3, we discussed who was involved in decision making about drug court admissions. As can be seen in Table 7.2, the processing of offenders begins with the determination of legal eligibility which is conducted by court personnel. A substance abuse screening and assessment is conducted by treatment staff on those individuals who satisfy the local drug court's legal criteria. Should a defendant meet legal and clinical eligibility requirements, at a minimum both treatment and court personnel at each site played a role in providing information to the drug court judge who ultimately makes the final decision.

Contrary to the old probation model where the criteria used to refer defendants to treatment were largely subjective in nature, these drug courts have made a basic improvement in objectifying the process by using standardized clinical measures. However, the degree to which these measures are actually employed in the admission process could not be ascertained in this evaluation given the absence of necessary over-ride information. Table 7.2 outlines the specific legal and clinical eligibility requirements used to determine eligibility and also exclude defendants referred to drug court. As can be seen in Table 7.2, these procedures requires collaboration and cooperation between drug court and treatment personnel.

Table 7.2 Cross-site Comparisons of Program Eligibility Requirements

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
Who determines Legal eligibility	Probation	Prosecutor	Arraignment Court & Probation	Prosecutor
Legal criteria used to exclude	Violent Offenders	Violent Offenders	Violent & Felony Offenders	Violent & Multiple Offenders
Who determines clinical eligibility	Clinical staff	Clinical staff	Clinical staff	Clinical staff
Standardized Instruments	ASI	SASSI	ASI and others	ASI and others
Treatment criteria used to exclude	Mental health issues, Substance Abuse Severity	Substance Abuse Severity, Mental Health, Motivation	Substance Abuse Severity, Mental Health Issues	Mental Health Issues and Lack of Motivation

Although observations of drug court staffings and status hearings were not a formal part of the research, members of the research team observed and documented both. At each site, there was collaboration and cooperation among court and treatment staff. Client treatment attendance, performance and progress were frequently discussed between team members during "staffings".

However, observations of the judge-participant dialogue revealed that the most common discussion topics centered upon general well-being, drug-test results, AA/NA

meeting attendance, and areas pertaining to either housing or employment. Only on a few occasions were discussions of treatment performance, participation and attendance (which occurred during the staffing) follow through into the courtroom dialogue. In this sense, it can be said that each of the courts have a relatively low-level of treatment integration, placing more emphasis upon aspects of participants lives other than the treatment they are receiving. On the other hand, the four drug courts seem to be highly integrated in relation to the decision-making surrounding the use of sanctions and rewards. Only on very few occasions did we observe the judge override recommendations made by treatment staff.

Cross-Program Familiarity Issues

Although treatment staff from all sites are reportedly involved in court operations by attending pre-court staff meetings and court hearings, only five out of twenty court personnel interviewed indicated they attended any treatment sessions. Only two persons indicated attending treatment sessions on more than one occasion.

Court personnel were able to describe in a general way the roles that treatment personnel play within the drug court context and they had basic knowledge of the content of the drug treatment program. However, court personnel seemed less knowledgeable about the details of the treatment process. For example, only four respondents could, when asked, provide specific details about treatment screenings and assessments such as the type of screening test used. Court personnel's knowledge of treatment operations also appears to be role specific. Case managers and judges seem more informed about how eligibility was determined and what information was used from assessments to make admission decisions than defense counsel and sheriffs who seemed less informed about how treatment decisions were being made.

Court staff from three sites indicated that they met regularly with treatment staff, usually at pre-hearing staffings immediately before court hearings. The Bakersfield drug court did not conduct pre-court staffings. At this site, court status hearings are adjourned to discuss problem cases when they occur.

Interviews with drug court personnel indicate that decision making about participant progress is based on multi-disciplinary information provided by members of the drug court team who are present at pre-court staffings. This is consistent with descriptions contained in the policies and procedures manuals and pre-court staffings we observed during our site visits. While there are cross-site variations in the composition of these staffings, those attending were comprised of both treatment and court personnel. Finally, court personnel reported few conflicts with treatment personnel. The difficulties they did encounter centered on the impact of staff changes and turnover.

Integration According to Treatment Personnel

Some of the items in surveys of treatment personnel also addressed integration (See Table 7.3). Most counselors reported regular contacts with the drug court staff[11] as well as with supervision (e.g., probation). Treatment staff report frequent attendance at drug court hearings, and overall felt that their communication with the court was bilateral and ranked their communication as just slightly better than average in terms of effectiveness. Finally, all counselors at each of the four courts reported that their agencies generated drug testing results and shared those results with the drug court team.

Another area that stands out in terms of the delivery of treatment services involves the treatment planning process (presented in Chapter 5). While every program reported developing individualized treatment plans for drug court clients, very few reported that the client played a significant role in developing their plans. While drug court personnel often attended treatment-planning meetings, few counselors reported that court personnel were actively involved in the treatment planning process. This suggests that both parties could provide more useful input in this process.

Table 7.3 Counsellor Survey Results related to Treatment Integration

	St. Mary Parish	*Creek County*	*Bakersfield*		*Jackson County*	
			Outpatient	Residential	Outpatient	Residential
Number of Respondents (Response %)	3 (50%)	3 (30%)	21 (62%)	16 (84%)	8 (53%)	3 (30%)
Regular Drug Court Contact?	100%	33%	79%	69%	86%	67%
Regular Probation Contact?	100%	33%	80%	100%	100%	100%
Drug Court Staff Aid in Treatment Planning?	0%	67%	37%	20%	50%	0%
Drug Court Staff Attend Planning Meetings?	100%	67%	21%	13%	100%	0%
Treatment Staff go to Court Hearings?	100%	67%	68%	75%	63%	0%
Is Information Sharing Bilateral?	100%	67%	74%	87%	100%	67%
Drug Testing Reports Shared with Court?	100%	100%	100%	100%	100%	100%
Mean "Info Sharing" Effectiveness Rating 1=Very 5=Not at All	1.9	2.0	2.4	1.9	1.8	3.0

At least in one site, the drug court personnel reported problems overseeing the activities of their community-based treatment programs, particularly around the issue of cancelled treatment meetings. On the other hand, courts which operated their own treatment services seemed much more able to gather information and exert influence over the quality and quantity of services delivered to their participants. Related to this is the issue of court personnel understanding what actually takes place in treatment. Again, staff at one court in particular were unable to distinguish between the services delivered

[11] The exception is counselors at Creek County (see Table 7.4). Note that two of the three counselors who responded from this site worked for a treatment program, which at the time of the evaluation, did not serve a large number of the drug court's clients. Since that time this program has become the sole provider of services for the court, so their communication with the court may have increased substantially.

in "treatment" and those delivered in the "support groups" (12-steps-based) that they also mandated clients to attend. In other words, in this site the court personnel were sending participants to services that they did not fully, or even partially understand.

This example is emblematic of a broader issue concerning the level of integration between court and treatment services that are needed in order to deliver a more effective intervention. There are several important consequences of court personnel having only limited knowledge of the techniques and realistic goals of substance abuse treatment, not the least of which is the impact on their expectations for the speed and degree of change which may be expected of participants during the typical drug court stay.

Most programs reported mechanisms like written reports, sharing of drug test results and attendance of both staff at treatment planning meetings and court hearings. Despite this, continued development of communication between the two parties appears useful. Similarly, cross training for each group might further aid in each side understanding the views and techniques of the other. While several judges expressed an interest in attending treatment groups, in order to better understand the process, they also generally thought that doing so would cause problems for the participants, in terms of their comfort level. In light of these concerns, it would seem particularly useful for treatment staff to periodically provide training sessions for court personnel, so that they can at least develop an academic understanding of the processes involved, even if there are practical barriers to the observation of actual treatment services.

Summary of Findings about Levels of Integration

What do these findings suggest? Perhaps, they are best summarized in terms of our previous discussion of levels of integration. The integration of court and treatment operations in the drug court context occurs at least at four levels.

- Treatment and court staff share similar views about the causes of and responses to substance abuse and criminal behavior. Court personnel believe substance abuse is related to and precedes criminal behavior – it is criminogenic.

- All sites indicate both court and treatment staff have worked together to develop policies and procedures and share financial responsibilities. Clearly, there are cross site differences in the degree this has occurred.

- Criminal justice and treatment staff generally work together to make decisions regarding the handling of individual cases. There is a division of labor and agreements on this process. Existing policies and procedures are in place to support this collaboration and cooperation in case planning, assessment, and drug testing. Intake decisions are a case in point. Intake decision making tends to be compartmentalized. The determination of eligibility begins with a legal screening conducted by court personnel. This is typically followed by treatment screening and assessments. The

final admission decision appears to be a joint decision, however, override information was not available to test this empirically.

- Criminal justice staff have limited knowledge about substance abuse treatment. On the other hand, treatment personnel seem more knowledgeable about the criminal justice system in general and court operations in the drug court context. Although treatment staff from all sites were involved in drug court operations by attending pre-court staff meetings and court hearings themselves, only a few court personnel report attending any treatment sessions.

Summary

This chapter has explored integration issues between treatment and court operations in the drug court context. While each program has its own distinct characteristics, we find that the drug courts have institutionalized lines of communication between court and treatment operations through several common mechanisms: 1) conducting pre-court meetings where court and treatment staff are able to meet and discuss client progress; 2) combining court and treatment requirements for participants in the phase system; and, 3) placing representatives from both treatment and the courts on drug court steering committees and other decision making and policy making bodies.

Integration is not, however, simply a matter of cooperation and cross-program familiarity by staff, it involves different levels of system integration– philosophical, policy, and operations. The types of integration that are best for drug courts have yet to be demonstrated. Future research might consider such questions as these:

- What should key actors in criminal justice know about treatment?
- Does more communication, greater criminal justice involvement in the therapeutic process and greater treatment provider involvement in criminal justice process have any impact?
- Does collaboration and communication result in better treatment engagement and adherence, better or faster progress in treatment or better outcomes?

Drug courts are intended to incorporate treatment principles within a structured environment for monitoring the progress of the offender. In essence, drug courts integrate aspects of the treatment and criminal justice system to form a unique service delivery system. At the beginning of this chapter, we raised the empirical question about the extent that the integration of criminal justice and treatment services was characteristic of the four drug court programs in this study. It was suggested that the most important issue affecting drug court program operation and success appears to center on the effective collaboration and communication between both treatment and criminal justice agencies and personnel.

This integrated set of criminal justice and treatment services are intended to jointly promote abstinence and pro-social behavior. By design, various components of

criminal justice and substance abuse treatment systems are intended to work together as part of the drug court model to combine the coercive power of the court with what is hopefully effective and scientifically based treatment practices (Belenko, 1998:6). The findings in this chapter suggest that variability in integration at various levels at some drug courts may limit effectiveness in the delivery of the program.

The next two chapters examine how participant characteristics and functional components of the drug court model are associated with program completion and post-program recidivism. The analysis is intended to fill a gap in the research literature by addressing how some of the core components associated with the "black box" of the drug court model are related to program completion and post-program recidivism.

Chapter 8

Retrospective Study: Participant Characteristics, Program Fidelity Measures and Factors Associated with Program Completion

Overview

Previous chapters addressed the overall structure of each drug treatment court, the content of their respective treatment programs and the integration of treatment and drug court components. The next two chapters are concerned with how participant level compliance with the performance expectations of these drug court programs are related to program completion and post-program recidivism. These chapters examine how functional components of the drug court model and participant characteristics are associated with discharge outcomes and post-program recidivism. They are based on an analysis of 2,357 offenders who participated in these programs between January 1997 and December 2000. The analysis is intended to fill a gap in the research literature by addressing how some of the core components associated with the "black box" of the drug court model are associated with participant level results.

Drug treatment courts require that participants comply with certain program requirements including: attendance at status hearings, no new criminal conduct, abstaining from alcohol and drug use, and attending substance abuse treatment. This chapter examines participant compliance with programmatic requirements and assesses how program compliance and participant characteristics are associated with program completion.

Belenko (2001) notes that comparative data on the relationships between organizational components of the drug court and program completion is generally lacking in the research literature. Goldkamp et. al. (2001:42) suggests that the impact of the drug court – "the drug court effect"- derives from a number of program operations the salience of which is likely to vary across jurisdictions.

Other studies have focused on the relationship between participant characteristics and completion of the drug court program. These studies suggest that program completers tend to have different characteristics than non-completers. For example, Peters et. al. (1999) found that a number of participant characteristics were positively associated with discharge outcomes in Escambia County. Successful completion of the drug court program was associated with such characteristics as being employed, living with parents and having completed high school or obtained a GED. And, graduates were more likely to report marijuana and alcohol use as their substance of choice in contrast to terminated participants who were more likely to report problems with cocaine and opiate use.

The goals of this chapter are threefold: (1) provide an overview of participant characteristics of each drug court program; (2) examine the integrity of each program across several program fidelity measures (drug testing, treatment attendance, and program participation); and, (3) identify factors associated with program completion.

Findings indicate that in some jurisdictions there are gaps between drug court programs as designed and actual drug court programs in operation that may pose a challenge to the integrity of those programs. Generally speaking, the findings also indicate that participant compliance with drug court protocols are positively associated with graduation outcomes. While compliance with program requirements are the most important factors associated with graduation, other factors, such as participant characteristics, also play a significant role.

The chapter is organized as follows: The first section presents bivariate cross-tabular descriptions of participant characteristics and examines how they are associated with program completion. The second section examines program completion rates across a variety of program fidelity measures. Multivariate logistic regression models are introduced in the last section of the chapter to assess the salience of these factors on program completion.

Methods

To understand how drug court operations are related to discharge outcomes, this study includes an analysis of 2357 offenders who were enrolled in the four drug court programs between January 1997 and December 2000. This sampling frame consists of all enrollees in drug court, regardless of their level of participation. As the study is not designed to assess the impact or success of drug court programs, there is no comparison or control group. The information presented in this chapter is based on participant data obtained from drug court and treatment records (including: offender characteristics, participant attendance in drug court, participation in treatment, drug testing as well as program discharge status). Policy level information was obtained from client handbooks, policy and procedure manuals and interviews with drug court personnel (See Chapter 2 for more information).

Program Discharge and Completion Results

Table 8.1 presents aggregate program completion rates for each of the four sites. Overall, 33% of the 2357 participants completed drug court through graduation and 67% were expelled. Cross-site comparisons indicate that graduation rates range between a low of 29% at the Jackson County drug court to a high of 48% at the Creek County drug court. Graduation rates in this study are lower than reported nationwide. In his review of 37 drug court research evaluations, Belenko (2001:28) reports that graduation rates from eight drug courts programs averaged 47% and ranged between 36% and 60%.

Table 8.1 Cross Site Comparisons of Program Completion Outcomes

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
%	32	68	100	48	52	100	36	64.8	100	29	71	100	33	67	100
N	70	150	220	93	99	192	262	461	723	354	868	1222	779	1578	2357

G=Graduated T=Terminated O=Overall

Sample Characteristics

Cross-site comparisons of demographic characteristics of participants are presented in Table 8.2. Overall, the majority of participants in the study are males (65%). This is consistent across sites with the exception of the Bakersfield drug court where the there are more female (54%) than male (46%) participants. There are also few age differences across sites. Drug court participants' ages range between 17 and 64 with a mean age of 31 years (not shown).

Approximately half of all drug court participants are white (51%). Non-white participants are predominately found at the Jackson County (68%) and the St. Mary Parish (46%) drug court programs. The race and ethnic composition of drug court participants roughly reflects the population demographics of each area.

Overall, most drug court participants are not married (86%). And, less than half of all participants (42%) have dependents. Participants with dependents range from a low of 13% in Bakersfield to a high of 59% in Creek County.

With the exception of Creek County where most participants were employed at the time of their admission (63%) and had completed their high school education (63%), participants at the three other sites were typically unemployed and most had neither completed high school nor obtained their GED. The percent of participants who completed high school or obtained a GED ranges from a high of 63% at Creek County to a low 29% in Bakersfield.

Characteristics of Participants By Discharge Status

Turning from a description of overall participant characteristics to an examination of how these demographic variables are associated with graduation (Shown on the right of each column), Table 8.2 also presents cross site analyses of the association between demographic factors and program graduation. The dependent variable here is rate of program graduation (0-100%). T-tests are performed on all dichotomous demographic variables and analysis of variance is analyzed for all variables involving multiple categories.

Table 8.2 Overall Cross-Site Demographic Characteristics of Participants and Analysis of Variance of Graduation Status

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
Gender															
1) Male	80	176	31	79	151	48	46	332	34	72	880	27	65	1539	31
2) Female	20	44	36	21	41	49	54	391	38	28	342	35	35	818	37
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G T-Test Sig.												1:2***			1:2***
Race															
1) White	54	118	37	79	152	49	69	496	38	32	396	42	51	1162	41
2) Non-white	46	102	25	21	40	45	31	227	33	68	826	23	49	1195	26
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G T-Test Sig.												1:2***			1:2***
Age															
1) 19 or Younger	16	34	18	12	23	26	3	24	38	19	237	18	13	318	20
2) 20-29	34	76	33	29	56	46	32	230	37	35	426	31	33	788	34
3) 30-39	37	82	33	32	61	49	44	316	37	29	356	30	35	815	34
4) 40 or Older	13	28	43	27	52	60	21	153	34	17	203	36	19	436	39
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G ANOVA Sig.			1:4*			1:4**				1:2***;1:3***;1:4***			1:2***;1:3***;1:4***		
Marital Status															
1) Married	10	21	48	23	44	52	17	126	30	8	36	58	14	227	41
2) Not Married	90	199	30	77	147	48	83	597	38	92	421	28	86	1364	34
Total	100	220	32	100	191	48	100	723	36	100	457	29	100	1591	36
% G T-Test Sig.												1:2***			
Number of Dependents															
1) None	61	135	29	41	79	48	87	223	56	46	203	32	58	640	41
2) One	10	22	36	28	53	53	5	14	86	26	114	20	18	203	35
3) Two or more	29	63	37	31	60	45	8	20	55	28	124	35	24	267	39
Total	100	220	32	100	192	48	100	257	57	100	441	29	100	1110	40
% G ANOVA Sig.									1:2*		1:2*;2:3**				
Education															
1) Less than HS	23	50	30	6	11	55	7	32	25	5	18	6	9	111	27
2) Some HS	41	91	31	31	60	30	68	332	37	44	164	23	51	647	32
3) HS or Equivalent	27	59	34	58	111	56	11	53	38	36	136	36	28	359	42
4) Post HS Education	9	20	35	5	10	70	14	68	43	15	55	38	12	153	42
Total	100	220	32	100	192	48	100	723	36	100	373	29	100	1270	36
% G ANOVA Sig.					2:3***;2:4*					1:3**;1:4**;2:3**;2:4*			1:3**;1:4**;2:3**;2:4*		
Employed at Admission															
1) Yes	33	72	39	63	121	52	28	200	47	43	202	40	37	595	45
2) No	67	148	28	37	71	42	72	523	32	57	269	22	63	1011	30
Total	100	220	32	100	192	48	100	723	36	100	471	29	100	1606	35
% G T-Test Sig.									1:2***			1:2***			1:2***

% - reflects the overall percent of participants.
%G - reflects the percent of participants graduating.
***p<.001, **p<.01, *p<.05; two-tailed tests

Table 8.2 indicates several statistically significant demographic differences between program graduates and terminated participants. At one or more sites, statistically significant demographic differences include: gender, race, age, marital status, number of dependents, education, and employment status.

Differences by gender in program completion are statistically significant. Women (37%) are more likely to graduate than men (31%). More white participants graduate from drug court (41%) than non-whites (26%). The pattern between race and program completion is consistent across all four sites with fewer non-white than white participants graduating from drug court. A higher percent of older participants graduate than younger participants, with younger participants (aged 19 and under) being the least likely to graduate.

Although few participants were married (14%), married participants are somewhat more likely to graduate (41%) than participants who were not married (34%). The only statistically significant differences in marital status were found at the Jackson County drug court. And, there is a curvilinear relationship between number of dependents and overall completion rates. This relationship varies by site with significant differences at both the Bakersfield and Jackson county drug court locations.

Overall, participants who have completed high school are more likely to graduate (42%) than participants who have not completed high school (32% and 27%). These educational differences are statistically significant at both the Jackson County and Creek County drug courts. Employment status at admission is also positively associated with program completion. This relationship is statistically significant at both the Jackson County and Bakersfield drug courts.

Substance Use Profiles

Table 8.3 presents cross-site information about participant substance use histories. Data was obtained from individual treatment and drug court files and available for 1618 or 69% of the 2357 participants in the study. Drug court participants can be characterized as poly-substance users with over 90% reporting lifetime use of two or more substances.

The most frequently used substances are marijuana and alcohol, however, the use of other drugs such as cocaine/crack (44%) amphetamines (44%) and opiates (13%) were also reported. Overall, there are no differences between graduates and terminated participants in the use of specific substances. There are two site-specific exceptions. The percent of graduates reporting prior amphetamine use (33%) at the Jackson County site is larger than reported by terminated participants (15%); the percent of graduates reporting prior opiate use (11%) at the Bakersfield site is lower than reported by terminated participants (23%). Participant drug use in the thirty-day period prior to admission to drug court also varies across sites but is consistent with lifetime use reported above.

Table 8.3 Cross-Site Comparisons of Participant Substance Abuse Profiles

Substance Use History	St. Mary Parish			Creek County			Bakersfield			Jackson County			Total		
Lifetime History	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Alcohol	97.1	95.3	95.9	90.3	87.9	89.1	67.9	69.2	68.7	94.5	86.8	88.8	81.6	805	80.8
Marijuana	94.3	92.7	93.2	100	100	100	58.8	59.9	59.5	83.6	85.6	85.1	75.9	76.8	76.5
Cocaine/Crack	80.0	82.7	81.8	24.7	33.3	29.2	30.9	29.7	30.2	56.3	52.7	53.6	42.0	45.2	44.1
Amphetamines	7.1	4.0	5.0	54.8	62.6	58.9	69.8	66.2	67.5	32.0	15.2	19.7	50.6	40.1	43.7
Opiates	21.4	22.7	22.3	6.5	8.1	7.3	11.1	22.8	18.5	0.8	1.7	1.4	9.2	14.4	12.6
Other	42.9	36.0	38.2	24.7	23.2	24.0	10.3	10.4	10.4	9.5	12.1	14.1	19.0	15.8	16.9
(N)	70	150	220	93	99	192	262	461	723	128	355	483	553	1065	1618
Use Last 30 Days															
Alcohol	50.0	41.3	44.1	2.2	39.4	21.4	52.7	56.4	55.0	72.7	60.8	64.0	48.5	54.2	52.2
Marijuana	45.7	38.0	40.5	96.8	88.9	92.7	41.2	47.7	45.4	58.6	63.1	61.9	55.2	55.3	55.3
Cocaine/Crack	42.9	31.3	35.0	24.7	30.3	27.6	19.1	21.7	20.7	25.0	30.4	29.0	24.4	26.8	26.0
Amphetamines	-	-	-	-	26.3	13.5	51.5	51.2	51.3	7.0	5.9	6.2	26.0	26.6	26.4
Opiates	10.0	14.7	13.2	-	1.0	0.5	5.3	15.0	11.5	-	0.6	0.4	3.8	8.8	7.1
Other	10.0	4.7	6.4	8.6	5.1	6.8	9.2	8.9	9.0	2.3	2.8	2.7	7.6	5.9	6.5
(N)	70	150	220	93	99	192	262	461	723	128	355	483	553	1065	1618

G=Graduated T=Terminated O=Overall

Prior Experience With Substance Abuse Treatment

Cross-site information regarding prior experiences with treatment for substance use was available for a total of 1490 participants or 63% of the entire sample. As shown in Table 8.4, the majority of participants (72%) did not receive substance abuse treatment services prior to their admission to the drug court program. The fact that they are receiving substance abuse treatment for the first time stands in sharp contrast to other drug courts reported by Belenko (2001:21) where most participants report having previously received substance abuse treatment services. There are, however, cross-site variations in first time treatment experiences. At the Jackson County and St. Mary Parish drug courts, between 52%-62% of participants are receiving substance abuse treatment for the first time. This is in contrast to the Creek County and Bakersfield drug courts where 73%-82% of the participants had never received prior substance abuse treatment.

An examination of the relationship between prior substance abuse treatment and discharge status is also presented in Table 8.4. Here we find that prior treatment experience is negatively associated with drug court graduation. A larger percent of participants (38%) with *no* prior treatment experience graduated from drug court than those *with* prior treatment experiences (28%). With the exception of the St. Mary Parish drug court, the negative relationship between prior treatment experience and graduation holds across all sites and is statistically significant at both the Creek County and Bakersfield drug courts.

Table 8.4 Cross Site Comparisons of Participant Substance Abuse Treatment Histories

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
Prior Tx Experience															
1)Yes	48	106	33	27	52	37	18	129	22	38	133	27	28	420	28
2) No	52	114	31	73	140	53	82	594	39	62	222	31	72	1070	38
Total	100	220	32	100	192	48	100	723	36	100	355	30	100	1490	36
% G T-Test Sig.						1:2*			1:2***						1:2***

Criminal History Profiles

Obtained from NCIC records, Table 8.5 presents prior criminal history information for drug court participants at each site. Overall, the majority of participants (82%) had one or more prior arrests with a median of two and range between 0 and 77[12]. Among participants with prior arrests, 23% had only one prior arrest and the remaining 59% had two or more prior arrests. The median number of prior arrests at each site ranges from a low of one to a high of four.

As expected, the largest percent of participants with no prior arrests were from Jackson County (22%) and Creek County (35%) where some program tracks focus on first and second time offenders. And, the number of arrests prior to entering drug court are negatively associated with graduation at both the Bakersfield and Jackson County drug courts. The Creek County and St. Mary Parish drug courts, however, show few differences in the number of prior arrests by completion status.

Table 8.5 Cross Site Comparisons of Participant Prior Arrest Histories

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
Number of Prior Arrests															
1) None	11	24	46	35	67	48	9	62	55	22	270	40	18	423	44
2) One	23	51	27	21	40	53	15	106	58	29	348	32	23	545	38
3) Two or More	66	145	31	44	85	47	76	555	30	49	604	22	59	1389	28
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G ANOVA Sig.								1:3***;2:3***			1:2*;1:3***;2:3***			1:3***;2:3***	
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Median	2.50	3.0	3.0	1.0	1.0	1.0	3.0	5.0	4.0	1.0	2.0	1.0	1.0	2.0	2.0
Range	0-18	0-28	0-28	0-13	0-12	0-13	0-31	0-77	0-77	0-14	0-20	0-20	0-31	0-77	0-77
Mean	3.39	3.67	3.58	1.73	2.15	1.95	4.19	8.23	6.77	1.59	2.45	2.20	2.64	4.24	3.71
St. Dev.	3.29	3.72	3.59	2.10	2.81	2.50	4.60	8.83	7.82	1.95	2.66	2.50	3.43	5.93	5.29

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduated T=Terminated O=Overall

[12] This data presentation excludes the initiating drug court arrest.

Table 8.6 presents information about the types of prior arrest offenses. Findings indicate that the majority of participants (51%) prior arrest offenses are drug related. With the exception of the Creek County drug court where the second most frequent prior arrest offense is DUI/DWI, the second most frequent prior arrest offense at the other three sites are property crimes. This basic pattern holds across all sites as well as by completion status.

Table 8.6 Cross-Site Comparisons of the Types of Prior Arrests Offenses[a]

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
Types of Prior Arrests	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Personal	15.9	11.7	13.0	10.4	5.0	7.6	9.7	12.7	12.7	9.4	9.3	9.3	11.5	10.4	10.8
Property	25.1	31.4	29.5	16.5	21.8	19.2	19.1	25.1	23.1	23.5	28.3	27.1	21.3	27.3	25.5
DWI/mv	6.2	4.7	5.2	34.0	23.6	28.7	2.8	3.5	3.2	2.3	2.4	2.4	6.1	4.0	4.7
Drug Related	35.5	40.2	38.8	32.8	42.3	37.7	56.4	47.7	50.7	58.6	53.3	54.7	52.8	49.6	50.6
Other	17.3	12.4	13.6	6.3	7.3	6.8	8.9	11.0	10.3	6.2	6.6	6.5	8.3	8.6	8.5
Total %	100	100	100	100	100	100	1002	100	100	100	100	100	100	1001	100
N	70	50	220	93	99	192	62	461	723	354	868	1222	779	578	2357

G=Graduated T=Terminated O=Overall

a. Data presented reflects average percentages

Integrity of Drug Court Program Operations and Protocols

The drug court provides a programmatic process to address the chronic nature of addiction through drug testing, sanctions, frequent status hearings and treatment. Goldkamp et. al. (2001) and Belenko (2001:22) argue that more information is needed about these functional components of drug court operations to learn how clients, staff, and organizational factors interact to affect client and system outcomes. By assessing the integrity of several program fidelity measures, this section of the chapter examines the "black box" of the drug court model. In three key areas, policy level descriptions of drug court program protocols are measured against actual drug court practices among both terminated participants and program graduates. These fidelity measures include: program duration, drug testing and treatment attendance requirements. Findings indicate that in some jurisdictions there are gaps between drug court programs as designed and drug court programs in operation that may pose a challenge to the integrity of those programs.

Drug Court Attendance Requirements

As described in Chapter 3, potential drug court participants are informed about various program performance expectations including the length of the program. Table 8.7 compares policy level descriptions of the length of the four drug court programs with how much time participants actually spent in drug court. Overall, program participation ranges from one day to forty-five months with a median participation length of eleven months. As expected, participation is positively associated with program completion status. The 779 graduates took a median of fourteen months to complete the program with a range between three months and forty-five months. Median length for the 1578

terminated participants was eight months and ranged between one day and forty-four months. Overall, participants who successfully complete the drug court did so in about 14 months (median) or 15.7 months (mean).

Table 8.7 Cross-site Comparisons of Drug Court Attendance

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
Length of Program	15 month			3,6,9, & 12 months			12 months			12 months					
Actual Attendance	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Range in Months	9-42	1-44	1-44	3-33	1-36	1-36	6-33	1-42	1-42	6-45	1-43	1-45	3-45	1-44	1-45
Median Months	20	7.7	11	12	6	10	14	6	10	14	9	12	14	8	11
Mean Months	20.9	9.8	13.3	12.6	8.8	10.6	14.6	8.1	10.5	16.4	11.0	12.6	15.7	9.9	11.8
St. Dev.	8.1	8.0	9.4	5.7	7.1	6.7	4.4	6.6	6.7	6.0	7.3	7.4	6.1	7.3	7.4
Total N	70	150	220	93	99	192	262	461	723	354	868	1222	779	1578	2357

G=Graduated T=Terminated O=Overall

Table 8.8 examines this same data differently. It compares policy level descriptions of the intended or scheduled length of the drug court program with the *percent* of time participants actually spent in the program. Differences in the amount of time spent in drug court by completion status are shown as a percentage of the scheduled program length. Terminated participants attended, on average 67% (median) of the program's scheduled length before they were discharged. In contrast, graduates completed the program in 117% (median) of the program's intended scheduled length.

It is important to note that these findings indicate broad variations and, perhaps, disparities, in the amount of time it takes participants to complete the drug court program[13]. The amount of time taken by a third of the participants to complete the program exceeds program protocols. In fact, 38% of the graduates completed the program only after participating for more than 125% of the program's scheduled time. There are cross-site variations in completion differentials exceeding 125% that range from 30% of the graduates at Bakersfield to 61% of the graduates at St. Mary Parish.

In addition, a few graduates (5%) completed the program in less than 76% of the scheduled time. The percent of graduates completing the program in less than 76% of the scheduled time ranges from 2% in Jackson County to 13% at St. Mary Parish.

These findings also suggest that a significant number of people are terminated from drug court after having participated for an amount of amount of time that exceeds the intended length of the program. In fact, 18% of the terminated participants were unsuccessfully discharged from the program after attending more than 125% of the program's scheduled length. The percent of terminated participants attending more than 125% of the scheduled program length ranges from 14% at St. Mary Parish to 23% at the Jackson County drug court. Findings indicate that at each of the four drug courts, the

[13] There are many legitimate reasons for overriding program protocols. Here, it is the number of overrides that is at issue.

actual length of time clients participated was extended beyond program protocols. Overall, 54% of the graduates and 23% of those who were terminated actually attended the program for an amount of time that exceeded these standards.

Table 8.8 Cross-Site Comparisons of the Actual Length Drug Court Program Participation

Program Length	*St. Mary Parish*			*Creek County*			*Bakersfield*			*Jackson County*			*Totals*		
% Scheduled Length	15 month			3,6,9, & 12 months			12 months			12 months					
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
0-25%	0	17.4	11.8	0	25.3	13.0	0	25.2	16.0	0	11.4	8.1	0	16.9	11.3
26-50%	0	32.0	21.8	1.1	26.2	14.1	0.4	28.8	18.6	0.3	20.9	14.9	0.4	24.5	16.6
51-75%	12.9	22.0	19.1	9.7	12.1	10.9	3.4	16.7	11.9	2.0	18.6	13.8	4.3	18.0	13.5
76-100%	21.4	14.0	14.1	38.7	14.2	20.9	44.7	13.7	18.6	43.7	20.5	18.2	41.5	17.5	25.4
101-125%	4.3	0.7	4.1	11.8	7.0	14.5	21.7	4.5	17.1	15.0	6.0	17.7	15.9	5.2	8.7
>125%	61.4	14.0	29.1	38.7	15.2	26.6	29.8	11.1	17.8	39.0	22.6	27.3	37.9	17.9	24.5
% Totals	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Mean %	139%	65%	88%	127%	75%	100%	122%	68%	87%	137%	92%	104%	131%	81%	98%
Median %	133%	53%	73%	117%	50%	100%	117%	50%	83%	117%	75%	100%	117%	67%	92%
Range	60-280%	7-293%	7-293%	42-300%	8-300%	8-300%	50-275%	8-358%	8-350%	50-375%	8-358%	8-375%	42-375%	7-358%	7-375%
N	70	150	220	93	99	192	262	461	723	354	868	1222	779	1578	2357

G=Graduated T=Terminated O=Overall

Drug Testing Protocols

As previously discussed in Chapter 3, while a drug testing protocol is in place at each of the four sites, there are cross-site variations in the required frequency of drug testing. On the basis of interviews with court personnel and an examination of the drug testing protocol at each site, we calculated the minimum number of drug tests required for program completion. Information about the *expected* number of drug tests required by program protocols is summarized in Row 2 of Table 8.9. Drug testing information was available for 1935 (82%) of the 2357 drug court participants.

In order to explore the relationship between the drug testing protocols and actual drug testing practices, we calculated the minimum number of drug tests each participant was required to receive over the course of their program participation with the number of drug tests each participant actually received.

Example

Participation Length: 10 weeks

Number of Drug Tests Required: 2-3 times per week

Actual Number of Drug Tests Received: 21 tests

Participation length (10 weeks) x
Minimum number of tests required per week (2) = 20 Total tests

Actual Number of Drug Tests (21) /
Minimum Number of Expected Tests (20) = 1.05

Participant received 105% of the expected minimum required tests.

This method provides a conservative estimate and introduces a control for program participation length by projecting the minimum number of drug tests required given the amount of time each client participated in the program.

Findings in Table 8.9 indicate that the average percent of drug tests received versus the number required ranges between 0% and 390% and varies both by completion status and by jurisdiction. Controlling for the length of program participation, drug court graduates have a higher average drug testing completion rate than terminated participants.

Overall, more drug tests were administered to graduates at the St. Mary Parish and Jackson County drug courts than called for by the drug testing protocols of those programs. And, fewer than the expected number of drug tests were administered to terminated participants at both the Creek County and Bakersfield drug courts.

The eighth row of Table 8.9 presents information on the number of participants who received 70% or more of the drug tests than called for by the drug testing protocol. To err on the side of caution, the 70% figure serves as a purely arbitrary but more realistic expectation and conservative benchmark for evaluating minimum standards of program delivery.

Table 8.9 Comparison of Actual Drug Testing Practices with Drug Testing Protocols

Drug Tests	*St. Mary Parish*			*Creek County*			*Bakersfield*			*Jackson County*			*Totals*		
Percent Expected	15 month			3,6,9, & 12 months			12 months			12 months					
Actual % of Tests	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
0-25%	0	6.8	4.6	0	35.7	19.9	5.4	44.7	29.6	0.9	31.1	21.9	1.8	31.7	21.7
26-50%	0	10.1	6.9	16.7	25.5	21.6	27.2	19.5	22.4	8.1	22.5	18.1	13.8	20.6	18.2
51-75%	0	18.9	12.8	28.2	21.5	24.4	27.2	13.6	18.9	21.2	14.5	16.6	21.5	15.4	17.5
76-100%	1.4	10.1	7.4	38.4	4.0	19.3	15.2	10.3	12.1	26.8	15.5	18.9	22.2	12.8	15.9
101-125%	8.6	13.6	11.4	12.9	8.2	10.3	3.3	4.7	4.2	21.5	6.7	11.1	13.7	7.2	9.4
126-150%	24.3	13.5	17.0	3.8	5.1	3.9	2.1	2.4	2.3	10.3	4.7	6.4	8.8	5.1	6.4
>150%	67.1	27.0	39.9	0	1.0	0.6	14.6	4.8	10.5	11.2	5.0	6.9	18.2	7.2	10.9
Total %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
% Receiving > 70% Over Expected	100	69.6	80.3	57.7	17.3	35.8	43.5	25.6	33.5	75.7	34.7	47.7	67.2	35.3	46.1
Mean %	200%	116%	143%	76%	48%	60%	94%	48%	66%	98%	58%	70%	105%	62%	77%
Median %	180%	110%	136%	76%	37.5%	59%	66%	31%	48%	94%	47%	67%	89%	48%	65%
Range	100-391%	0-323%	0-391%	26-138%	4-158%	4-158%	19-347%	0-288%	0-347%	23-216%	2-238`%	2-238%	19-391%	0-323%	0-391%
N	70	150	220	78	98	176	184	293	477	321	743	1064	653	1282	1935

G=Graduated T=Terminated O=Overall

Overall, 46% of participants received the minimum number of drug tests (70% or more) as called for by their respective drug testing protocols. This represents 67% of the graduates and 35% of those who were terminated. Variations in the percentage of participants who received 70% or more of the expected number of drug tests ranges from a high of 100% for graduates at St. Mary Parish to a low of 17% for terminated participants at the Creek County drug court.

These findings suggest that not all participants receive the number of drug tests called for by the program's drug testing protocol. Given that many terminated participants were not administered the expected minimum number of drug tests they were required to receive, future research should address the relationship between participant compliance with drug testing protocols and the rationale behind program discharge.

Treatment Attendance Requirements

At the centerpiece of the drug court program is the provision of substance abuse treatment services. To date, five major studies have been conducted that employ sound research methods to explore the efficacy of drug courts, and to measure the services delivered to offenders (Harrell, Cavanaugh, and Roman, 1998; Deschenes, Turner, and Greenwood, 1995; Goldkamp, White, & Robinson 2001; Peters and Murrin, 1998; Gottfredson et al, 2002). In each of these studies, the percentage of drug court clients participating in treatment varied considerably from 35 to 80 percent. For offenders participating in drug treatment services, the length of time in treatment also varied from under 30 days to over two years. Deschenes, Turner & Greenwood (1995) found that 77 percent of the drug court clients in Maricopa County participated in drug treatment. The general finding appears to be that the longer the period of time in treatment, the greater the likelihood that the offender will graduate from drug court. And, more importantly, participation in drug treatment reduces the likelihood of rearrest.

Previous chapters described actual treatment operations and the content of treatment sessions. This section of the chapter examines participant compliance with treatment attendance protocols. By comparing the minimum number of treatment sessions required by the substance abuse treatment protocol at each site against the actual number of treatment sessions participants attended, this study begins to explore how compliance with treatment protocols in the context of drug courts is related to discharge outcomes.

As used to assess drug testing protocols, this section also employs a 70% benchmark to measure minimum standards of program delivery. Table 8.10 examines the number of actual treatment sessions attended with the expected minimum number of treatment sessions required, controlling for length of program participation. Overall, 36% of drug court participants attended more than the minimum expected number of treatment sessions. However, the rate of treatment session attendance varies both by discharge status and by jurisdiction. The rate of treatment session attendance ranges from 25% at Bakersfield to 72% at the St. Mary Parish drug court. As expected, the frequency of treatment attendance is positively associated with more graduates (64%) attending a greater percentage of the required treatment sessions (70%) than terminated participants (24%). The percent of graduates attending 70% or more of required treatment sessions range from 99% at St. Mary Parish to a low of 37% of graduates at Bakersfield[14].

[14] It is interesting to also note that some drug court participants graduate from the program having completed less than 50% of the expected treatment sessions. For example, overall, 18.7% of the graduates attended less than 50% of the minimum expected number treatment sessions required to successfully complete the program (Not shown).

Table 8.10 Comparison of Actual Treatment Attendance with Program Requirements

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Totals*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Actual Number of Sessions Attended															
Mean	115.7	63.0	80.0	71.6	41.9	55.9	51.9	21.2	31.7	93.4	16.5	25.0	74.2	28.8	41.9
St. Dev.	38.1	46.5	50.3	20.6	31.2	30.5	22.2	18.4	24.5	41.8	27.9	38.3	37.4	34.2	40.7
Median	110	52	76	76	36	55	46	16	27	95	4	5	72.5	16	30
Range	53-209	1-243	1-243	30-130	2-131	2-131	22-120	0-91	0-120	24-176	0-162	0-176	22-209	0-243	0-243
	69	145	214	89	99	188	153	292	445	41	328	369	352	864	1216
Actual vs. Expected Sessions Attended															
0-25%	0	11.7	7.1	0	16.2	8.5	0	41.1	24.9	0	73.5	55.4	0	45.6	32.4
26-50%	0	17.3	11.8	3.4	21.2	12.8	36.6	26.0	30.5	17.1	11.0	15.0	18.7	18.3	18.4
51-75%	2.9	17.9	13.2	14.6	30.3	22.8	31.4	19.2	24.0	12.2	5.7	8.3	19.4	15.2	16.4
76-100%	24.6	21.4	22.6	61.8	19.2	39.4	20.2	11.0	14.6	17.0	4.3	7.4	31.2	11.1	16.9
101-125%	18.9	14.5	16.1	15.7	8.0	11.7	8.5	1.7	4.2	22.0	3.1	6.6	13.9	5.1	7.6
126-150%	20.3	6.2	10.8	3.4	2.0	3.2	3.3	1.0	1.8	17.1	1.8	4.5	8.3	2.4	4.2
>150%	33.3	11.0	18.4	1.1	2.0	1.6	0	0	0	12.2	0.6	2.8	8.5	2.1	3.9
Total %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Attended > 70%	98.6	58.6	72.2	83.1	38.4	59.0	36.6	17.1	25.2	70.7	10.7	22.3	64.5	24.1	35.8
Mean %	136%	84%	102%	91%	63%	76%	66%	40%	49%	102%	22%	39%	90%	43%	57%
Median %	134%	77%	96%	91%	57%	81%	58%	33%	47%	103%	5%	17%	87%	31%	50%
% Range	62-243%	2-283%	2-283%	36-155%	7-156%	7-156%	28-150%	0-150%	0-150%	26-191%	0-176%	0-191%	26-243%	0-283%	0-283%
N	69	145	214	89	99	188	153	292	445	41	328	369	352	864	1219

G=Graduated T=Terminated O=Overall

These findings suggest that a number of participants complete the drug court without having attended the requisite number of treatment sessions called for by program protocols. Conversely, there are a number of participants who did not complete drug court who attended more than the expected number of treatment sessions. Overall, 24% of terminated participants completed more than the 70% of the expected number of treatment sessions required and 4.5% attended more than 125% of the treatment sessions expected. As in the case of drug testing protocols, future research should address the relationship between participant compliance with treatment attendance requirements and the rationale behind program discharge.

New Arrests During Program Participation

One of the major goals of drug court programs is to reduce criminal offending behaviors. Consequently, arrests occurring during participation in drug court (in-program arrests) are considered serious infractions of the drug court contract. The data collection time-frame allowed researchers to obtain information about in-program arrest activity occurring between the date of admission through the date of program discharge. Obtained from NCIC records, Table 8.11 presents information on the incidence of arrests during drug court participation.

Overall, 33% of participants were arrested one or more times during their participation in drug court. A total of 17% of participants were arrested once and, 16% were arrested two or more times. There are cross-site variations in the percent of participants with in-program arrests and the frequency of arrests. A higher percent of participants at the Bakersfield drug court (54%) had in-program arrests and Bakersfield participants had the highest rate (27%) of multiple (two or more) in-program arrests. Fewer participants at the two rural sites have in-program arrests and they have the lowest rate of multiple arrests. The percent of participants with in-program arrests ranges from 13% at St. Mary Parish and 15% at Creek County to 27% at Jackson County and 54% at the Bakersfield drug court.

As expected, the frequency of in-program arrests is inversely related to program completion. This negative relationship holds across all four drug court programs and is statistically significant overall as well at both the Bakersfield and Jackson County drug court programs.

Table 8.11 Arrests During Drug Court Participation

Number of In-Program Arrests	*St. Mary Parish*			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
1) None	87	191	34	85	163	51	46	335	62	73	892	35	67	1581	42
2) One	12	27	22	11	21	33	27	196	20	12	150	23	17	394	22
3) Two or More	1	2	0	4	8	38	27	192	7	15	180	4	16	382	7
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G T-Test Sig.								1:2***;1:3***;2:3***			1:2***;1:3***;2:3***			1:2***;1:3***;2:3***	

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduated

Factors Associated with In-Program Recidivism

Step-wise logistic regression models are employed to test the combined effect of participant characteristics, drug test results and treatment attendance on in-program recidivism at each site. These multivariate models complement the bivariate analyses presented thus far by assessing the salience of each factor among control variables. The high degree of collinearity among many of the independent variables necessitates the use of the stepwise method. Separate models are estimated for each site as variations in missing cases prohibit the inclusion of all variables at all four sites. In-program arrest serves as the dependent variable of interest. Those not arrested are coded "0" and those who were arrested one or more times during program participation are coded "1." The logistic regression models predict the odds of arrest vs. no arrest at each site.

Table 8.12 presents the step-wise logistic regression results for the odds of in-program arrest at each of the four sites. Beginning with the St. Mary Parish program, we find no variables were significant in predicting the likelihood of in-program recidivism. In the Creek County drug court, only one variable is specified. Those participants who reported life-time use of amphetamines are 3.1 times more likely to be arrested during drug court participation than those participants with did not report use of amphetamines. With only one variable significant, the model is quite weak with only 3.3% of the variance in in-program recidivism explained.

Table 8.12 Odds Ratios from the Stepwise Logistic Regression of In-Program Arrests on Participant Characteristics and Compliance Measures[a]

	St. Mary Parish	*Creek County*	***Bakersfield***	*Jackson County*
	OR	OR	OR	OR
Demographics				
Female (male = 0)	.[b]	ns	ns	ns
Race (Caucasian = 0)	ns	ns	ns	ns
Age 20 – 29 (Less than 20 = 0)	ns	ns	ns	ns
Age 30 – 39 (Less than 20 = 0)	ns	ns	ns	ns
Age 40 + (Less than 20 = 0)	.[b]	.[b]	ns	.532**
On or More Dependents (None = 0)	ns	ns	.[c]	.[c]
High School Graduate (Less than High School = 0)	ns	ns	.[c]	.[c]
Employed at Admission (Not Employed = 0)	ns	ns	.584***	.[c]
Marital Status (Not Married = 0)	.[b]	.[b]	ns	.[c]
History				
Ever used Alcohol (No Use = 0)	.[b]	.[b]	ns	.[c]
Ever used Marijuana (No Use = 0)	.[b]	.[b]	ns	.[c]
Ever used Crack/Cocaine (No Use = 0)	ns	ns	ns	.[c]
Ever used Methamphetamines (No Use = 0)	.[b]	3.10*	ns	.[c]
Ever used Opiates (No Use = 0)	.[b]	.[b]	ns	.[c]
Ever used Other Substances (No Use = 0)	ns	ns	ns	.[c]
Received Prior Treatment (No Prior Tx = 0)	ns	ns	1.93***	.[c]
One or Two Prior Arrests (No Arrest = 0)	ns	ns	.632**	ns
Three or More Prior Arrests (No Arrest = 0)	ns	ns	ns	ns
Age at First Arrest (Log)	ns	ns	.308***	.435***
Age at First Use	ns	ns	.[c]	.[c]
Compliance				
Percent Positive UA .01 thru .08 (None = 0)	ns	.[b]	1.60*	ns
Percent Positive UA .09 thru .28 (None = 0)	ns	ns	2.70***	ns
Percent Positive UA .29 thru 1.0 (None = 0)	.[b]	ns	5.37***	1.36*
Percent Tx Attendance (Actual/Expected Minimum)	ns	ns	.267***	.[c]
Constant	.147***	.082***	79.97***	3.93
Cox & Snell R^2		.033	.120	.027
N	219	191	723	1221

***p<.001, **p<.01, *p<.05; two-tailed tests
[a] Unstandardized coefficients and standard errors available from author upon request.
[b] Variables not tested in model due to low cell counts.
[c] Variables not tested due to high percentage of missing cases.
ns-Not Significant

Unlike the previous two sites, several variables are significant in predicting the odds of in-program arrests at the Bakersfield drug court. First, those who were employed at the time of their admission to the drug court are nearly two times (inverse of .584) less likely to recidivate during drug court participation than those who were not employed. Second, those who received prior substance abuse treatment are nearly two times more likely to have in-program arrests than those receiving treatment for the first time. And, as age at first arrest increases, the likelihood of in-program recidivism decreases. Increases in the frequency of positive drug tests also increases the odds of in-program arrests. And, as treatment session attendance increases, the likelihood of in-program recidivism decreases. Overall, 12% of the variance in in-program recidivism is explained at the Bakersfield site.

With respect to the Jackson County drug court, three variables are significant in predicting the odds of in-program arrests. Participants aged 40 and older are nearly two-times (inverse of .532) less likely to recidivate during program participation than those who are younger. As in the case of the Bakersfield drug court, as age at first arrest increases, the likelihood of in-program recidivism decreases. Lastly, frequent percent positive drug tests increases the likelihood of in-program recidivism by 1.36 times.

Overall results of the analysis indicate that there is no one common predictor of in-program recidivism across sites. Those factors found to be predictive of in-program recidivism are mixed and site-specific. The most common predictor, age at first arrest and positive drug tests, were specified at both the Bakersfield and Jackson County drug courts. At both sites, as age at first arrest increases, the likelihood of in-program recidivism decreases. And, participants with frequent positive drug screens are more likely to have in-program arrests.

Positive Drug Tests During Program Participation

The requirement of abstinence from the use of alcohol and drugs is a core component of drug court programs. Frequent, random, and monitored drug testing is one of the *Key Components* of drug courts. However, other studies have not generally reported information about in-program drug use. Drug testing information presented here was available for a total 1942 drug court participants. (See Chapter 3 for a description of the drug testing protocols at each site.)

The relationship between positive drug tests and program completion is presented in Table 8.12. Overall, 76% of the participants tested positive one or more times for drug use during program participation. Among those participants testing positive, the median number of positive drug tests is 4 and ranges between 1 and 47.

There are both variations in positive drug tests by completion status and cross-site variations in the rate of positive drug tests. The percent of participants who tested positive one or more times ranges from a high of 84% in Jackson County to a low of 58% in Bakersfield. The median number of positive drug tests ranges from two at the Bakersfield drug court to five at the Jackson County drug court.

Overall, a total of 18% of the drug tests administered were positive. The Creek County drug court had the highest rate of positive drug tests (27%). The St. Mary Parish

drug court, conversely, had the lowest percent positive rate (8%). As expected, findings in Table 8.13 indicate that testing positive for drug use while participating in drug court is negatively associated with program completion. Overall, 50% of those with no positive drug tests graduated. For participants with one positive drug test, 30% graduated and those with two or more positive drug tests, 28% graduated. This negative association is statistically significant overall as well as at each of the four drug court locations.

Table 8.13 Cross-site Comparisons of In-Program Positive Drug Tests

Number of Positive Drug Tests	*St. Mary Parish*			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
1) None	26	57	53	27	47	79	42	201	42	16	170	49	24	475	50
2) One	15	32	19	12	22	36	18	87	26	14	148	34	15	289	30
3) Two or More	59	130	26	61	107	31	40	190	40	70	751	25	61	1178	28
Total	100	219	32	100	176	44	100	478	38	100	1069	30	100	1942	34
% G ANOVA Sig.		1:2***;1:3***			1:2***;1:3***			1:2**;2:3*			1:2***;1:3***;2:3*			1:2***;1:3***	
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Percent of Tests Positive	2.4	10.9	8.2	7.3	42.3	26.8	3.9	18.2	12.4	6.4	26.7	20.6	5.4	24.3	17.8
Median	4.0	3.0	3.0	4.0	4.0	4.0	2.0	2.0	2.0	4.0	5.0	5.0	4.0	4.0	4.0
Range	1-22	1-25	1-25	1-12	1-35	1-35	1-16	1-34	1-34	1-24	1-47	1-47	1-24	1-47	1-47
Mean	5.6	4.6	4.8	4.6	5.7	5.4	3.4	3.4	3.4	5.1	6.6	6.2	4.7	5.7	5.4
St. Dev.	5.14	4.24	4.48	3.10	5.60	4.96	2.84	3.96	3.59	4.51	5.78	5.50	4.17	5.47	5.15
Totals N	40	122	162	41	88	129	99	178	277	238	661	899	418	1049	1467

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduated T=Terminated O=Overall

The occurrence of positive drug tests and the occurrence of new arrests are two indicators of non-compliance with drug court program requirements. Table 8.13 examines the interaction between in-program arrests and positive drug tests on program completion.

Overall, 17% of drug court participants had neither an arrest nor a positive drug test during program participation. Among the 332 participants who had neither a positive test nor an in-program arrest, 62% graduated from drug court and 38% were terminated. The majority of participants (51%) only tested positive for drug use but were not arrested. Among the 992 participants who only tested positive for drug use, 35% graduated and 65% were terminated. A total of 7% of drug court participants were arrested during participation in drug court but had no positive drug tests. Among these participants, 20% graduated and 80% were terminated. And, among the 25% of participants who had tested positive and were arrested during program participation, 15% graduated from the drug court and 85% were terminated.

Overall findings from Table 8.14 suggest that participants who abstain from drug and alcohol use and refrain from participation in new criminal conduct are nearly three times more likely to graduate than those participants who had a drug court arrest and no

positive tests, and four times more likely to graduate than those who tested positive and were arrested during program participation.

Table 8.14 New Arrests and Positive Drug Tests by Discharge Status

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Totals*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
1) Neither Drug Court Arrest nor Positive UA	23	51	53	24	43	79	21	100	72	13	138	54	17	332	62
2) Positive UA and No Drug Court Arrest	63	139	27	61	106	33	21	100	67	60	647	32	51	992	35
3) Drug Court Arrest and No Positive UA	3	6	50	2	4	75	21	101	13	3	32	31	7	143	20
4) Both Drug Court Arrest and Positive UA	11	23	13	13	23	26	37	177	18	24	252	11	25	475	15
Total	100	219	32	100	176	44	100	478	38	100	1069	30	100	1942	34
% G ANOVA Sig.		1:2***;1:4***			1:2***;1:4***;3:4*			1:3***;1:4***;2:3*** 2:4***			1:2***;1:3**;1:4*** 2:4***;3:4*			1:2***;1:3***;1:4***;2:3*** 2:4***	

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduated T=Terminated O=Overall

Factors Predictive of Graduation/Termination

Step-wise logistic regression models are employed to test the combined effect of participant characteristics and program compliance measures on graduation at each of the four sites. These multivariate models complement the bivariate analyses presented thus far by assessing the salience of each factor among control variables. The high degree of collinearity among many of the independent variables necessitates the use of the stepwise method. Given that drug court graduation is largely a function of compliance with drug court protocols, the relationship will be explicitly tested in the models in order to ascertain which aspects of compliance are most critical. Further, participant characteristics significant in these models among program compliance measures will play a crucial, independent role. Successful completion of the drug court program (graduation) serves as the dependent variable of interest. Graduation is coded "1" and program termination is coded "0." The logistic regression models predict the odds of graduation versus termination at each of the four sites. The three compliance indicators include positive urinalysis, arrests during drug court participation, and treatment attendance measures.

While compliance with program requirements of the drug court are the most important factors associated with graduation, some participant characteristics also play a significant role. However, the findings are site specific. At one site, graduation is predicted by treatment attendance and clean drug tests suggesting a positive drug court effect. At other sites, characteristics of participants at entrance to the drug court program such as more serious criminal records and extensive treatment histories are associated with termination.

Table 8.15 Odds Ratios from the Stepwise Logistic Regression of Graduation on Participant Characteristics and Compliance Measures[a]

	St. Mary Parish	***Creek County***	*Bakersfield*	***Jackson County***
	OR	OR	OR	OR
Demographics				
Female (male = 0)	ns	Ns	ns	ns
Race (Caucasian = 0)	ns	Ns	ns	.620***
Age 20 – 29 (Less than 20 = 0)	ns	Ns	ns	ns
Age 30 – 39 (Less than 20 = 0)	ns	Ns	ns	ns
Age 40 + (Less than 20 = 0)	ns	Ns	ns	ns
On or More Dependents (None = 0)	ns	Ns	.[c]	.[c]
High School Graduate (Less than High School = 0)	ns	2.90***	.[c]	.[c]
Employed at Admission (Not Employed = 0)	ns	Ns	ns	.[c]
Marital Status (Not Married = 0)	ns	Ns	ns	.[c]
History				
Ever used Alcohol (No Use = 0)	.[b]	Ns	ns	.[c]
Ever used Marijuana (No Use = 0)	.[b]	.[b]	ns	.[c]
Ever used Crack/Cocaine (No Use = 0)	ns	Ns	1.56*	.[c]
Ever used Methamphetamines (No Use = 0)	.[b]	Ns	ns	.[c]
Ever used Opiates (No Use = 0)	ns	Ns	0.56*	.[c]
Ever used Other Substances (No Use = 0)	ns	Ns	ns	.[c]
Received Prior Treatment (No Prior Tx = 0)	ns	.391*	.254***	.[c]
One or Two Prior Arrests (No Arrest = 0)	ns	Ns	ns	ns
Three or More Prior Arrests (No Arrest = 0)	ns	Ns	.473***	.489***
Age at First Arrest (Log)	ns	Ns	ns	ns
Age at First Use	ns	Ns	.[c]	.[c]
Compliance				
Failure to Appear (No=0)	.[b]	.[b]	.105***	.109***
Drug Court Arrest (No = 0)	ns	Ns	.072***	.196***
Percent Positive UA .01 thru .08 (None = 0)	.244***	Ns	2.68***	3.88***
Percent Positive UA .09 thru .28 (None = 0)	.195***	Ns	ns	ns
Percent Positive UA .29 thru 1.0 (None = 0)	ns	.[b]	.[b]	.092***
Percent Tx Attendance (Actual/Expected Minimum)	11.29***	44.02***	21.74***	.[c]
Constant	.084***	.033***	.648	1.47**
Cox & Snell R^2	.244	.251	.362	.330
N	219	191	723	1221

***p<.001, **p<.01, *p<.05; two-tailed tests
[a] Unstandardized coefficients and standard errors available from author upon request.
[b] Variables not tested in model due to low cell counts.
[c] Variables not tested due to high percentage of missing cases.
ns-Not Significant

Table 8.15 presents the step-wise logistic regression results for the odds of graduation at each of the four sites. At the St. Mary Parish program, three program compliance measures are significant in predicting the likelihood of graduation. As expected, participants that do not have any positive drug screens are four times (inverse of .244) and 5 times (inverse of .195) more likely to graduate than those who test positive either in the "low" or "moderate" range. The model also reveals the importance of treatment attendance on graduation outcomes. As expected, participants who attend treatment sessions are more likely (11.3 times) to graduate from drug court. A total of 24% of the variance in program graduation is explained in this model.

Turning to an examination of the Creek County drug court, we find 3 variables significant in predicting the likelihood of graduation. As in the case of the St. Mary Parish drug court, treatment attendance has a strong positive impact upon graduation. The more treatment sessions attended, the more likely the participant will graduate. Participants who had received prior substance abuse treatment are less likely to graduate than those receiving treatment for the first time. Participants who never received any prior treatment are 2.55 (inverse of .391) times more likely to graduate. Those participants who had an educational level equivalent to a minimum of a high school diploma or GED are 2.9 times more likely to graduate than those who had less than a high school education. Overall, this model explains 25% of the variance in graduation at the Creek County Drug Court.

With respect to the Bakersfield program, several program compliance measures and participant characteristics are significant in predicting the likelihood of graduation. Turning to compliance measures, participants in the Bakersfield Drug Court who attend treatment sessions are also more likely to graduate. Participants with one or more in-program arrests are 13.9 (inverse of .072) times less likely to graduate than those who had no arrests during program participation. Similar findings pertain to those participants arrested for Failure to Appear. These participants are nearly 10 times less likely to graduate. Interestingly, participants with "low" percent positive tests are 2.7 times more likely to graduate than participants with no positive drug screens.

Characteristics of participants at entry to the program are also related to program completion. First, participants who had ever used opiates are 1.8 (inverse of .56) times less likely to graduate than participants with no prior history of opiate use. Similar to the Creek County drug court, participants having had prior substance abuse treatment has a negative effect. Participants with no prior treatment are 3.9 times (inverse of .254) more likely to graduate than participants who had prior substance abuse treatment. Third, participants with three or more prior arrests are over 2 times (inverse of .473) less likely to graduate than those participants with no prior arrests. The last demographic variable pertains to life-time history of crack/cocaine use which has a positive effect on the likelihood of graduation. Participants with a prior history of crack/cocaine use are slightly over one and a half times more likely to graduate than those participants with no history of crack/cocaine use. Overall, 36% of the variance in graduation at the Bakersfield Drug Court is explained.

The Jackson County drug court program has seven variables significant in predicting the likelihood of graduation. First, non-white participants are 1.6 (inverse of .620) times less likely to graduate from the program than white participants. Second,

participants with three or more prior arrests are 2.04 (inverse of .489) times less likely to graduate than participants with no prior arrests. Also similar to the Bakersfield drug court, participants with positive drug screens are 3.88 times more likely to graduate than those participants that had no positive drug screens. This positive effect is reversed, however, for participants who had positive urinalyses. As expected, these participants are nearly 11 times less likely to graduate than participants with no positive drug screens. And lastly, participants with one or more in-program arrests or one or more arrests for Failure to Appear are 5.1 times (inverse of .196) and 9.2 times (inverse of .109) less likely to graduate than those who had no arrests during program participation respectively. Unfortunately, due to missing cases, the percent treatment attendance variable is omitted from this model. However, the model is fairly robust with 33% of the variance in discharge outcomes explained.

Summary

This chapter focused on how key components of the drug court model and how compliance with the performance expectations of the drug court are associated with discharge outcomes. The chapter also addressed several issues about the integrity of the drug court model by comparing program protocols with actual drug court operations. In order to assess whether the drug court program was delivered as intended, program protocols were compared with actual drug court operations at each of the four sites. Some gaps were found between drug court programs as designed and actual program operations that pose a challenge to the integrity of these programs.

Although the overall mean length of attendance in drug court was within 98% of the scheduled length of the program, the amount of time some participants were in drug court exceeded the program's intended length. In each of these four drug courts, the length of the drug court program was extended. For example, about 25% of the participants were discharged from the program after attending more than 125% of scheduled program length. They represent 38% of the graduates and 185 of the terminated participants. While it appears that these drug courts are attempting to be flexible in tailoring program requirements to their clients, given the absence of data, it is unclear what criteria are used in making individual case decisions that override program requirements.

Actual compliance with drug testing protocols and compliance with treatment session attendance requirements also varies considerably among the four drug courts. Moreover, lack of compliance with these requirements is directly related to program completion. Offenders who did not provide the requisite number of drug tests or failed to appear for treatment sessions are more likely to be unsuccessfully terminated from the program. Regarding treatment attendance, most of the offenders whose cases result in termination were infrequent attendees of treatment sessions.

This chapter also examined whether compliance with the program requirements of the drug court program was associated with program completion. Adherence to program requirements should be expected and were found to be related to program completion. In-program arrests and positive drug tests were negatively related to program completion. Overall, 76% of the participants tested positive for drug use one or more times and 33%

were arrested during their participation in drug court. As expected, positive drug tests and in-program arrests are both associated with being terminated from the program. A total of 15% of those with in-program arrests and 30% with one or more in-program positive drug tests graduated from the program. Put differently, these drug court programs expect adherence to program requirements as a condition of remaining in the program. Participants terminated from the program are two to three times more likely to test positive for drug use and four to five time more likely to be arrested during their participation than those who successfully complete the program through graduation.

The findings reported here are similar to those reported by Goldkamp et. al. (2001) as they are mixed and site specific. Although not designed to assess the "success" or impact of drug court programs, the findings indicate that both key components of the drug court model and characteristics of participants were associated with program graduation and termination. Overall, results of the regression analyses indicate that compliance with program protocols (attendance at treatment, no drug use and no new criminal conduct) are the most important factors associated with program graduation. While these results are largely expected, there are a several patterns that emerge from these analyses that may bear further exploration. At two sites (Bakersfield and Creek County), it was found that participants with a history of prior substance abuse treatment are less likely to graduate than participants who are receiving treatment for the first time. The second pattern that emerges concerns participants serious criminal histories. At the two urban locations (Jackson County and Bakersfield), it was found that these participants are also less likely to succeed in drug court. Combined, these patterns suggest that some drug court programs may have difficulty in dealing with participants presenting more severe drug using and criminal behaviors.

Chapter 9

Cross-site Comparisons of Rates of Post-Program Recidivism

Overview

The major goal of drug court programs is to reduce the recidivism of drug involved offenders by changing their drug using habits. This chapter provides information about rates of post-program recidivism at each of the four drug courts and identifies factors associated with new criminal activity. Although a growing body of research literature consistently indicates positive results for drug courts across studies, questions remain as to what outcomes are most important and which factors affect those outcomes (Belenko, 2001; Peters, et. al 1999; Goldkamp, et. al. 2001).

In 1997, the U.S. General Accounting Offices (GAO) suggested that future research on drug courts should be designed to include comparisons between recidivism rates of drug court participants with those of a control group of offenders. As of 2001, Belenko reported that only six of the 37 studies he reviewed provided such information and only three studies distinguished between in-program versus post-program recidivism. More recent evaluations reporting such information include: Chester County, Pennsylvania (Brewster, 2001); Multnomah County, Oregon (Goldkamp et. al. 2001); Clark County, Nevada (Goldkamp et. al. 2001); Baltimore City, (Gottfredson, 2003); and, Ohio (Latessa et. al. 2002). While findings reported by these studies vary, the literature consistently indicates that recidivism rates for drug court participants are lower than comparison groups during the same follow-up period.

Several studies have used multi-variate techniques to examine factors associated with recidivism (Harrell, et. al. 1998; Peters, 1999; Goldkamp, 2001; and, Latessa, 2002). They found both program and participant characteristics were related to recidivism. Participant characteristics include: prior criminal record, prior treatment history, age, ethnicity, gender, and marital and employment status. Lower rates of recidivism were found among participants who were married, Caucasians, and participants with minor arrest histories. Factors associated with higher rates of recidivism include: participants whose primary substance abuse problem is cocaine, younger participants, and African Americans.

Program characteristics found to be associated with recidivism include sanctions, drug testing outcomes, and treatment attendance (Goldkamp, et. al. 2001). Lower rates of recidivism were found among program graduates and participants with higher rates of treatment attendance. As expected, higher rates of recidivism were found among participants with in-program arrests, higher in-program drug tests and among those terminated.

Consequently, the picture that seems to emerge is that drug courts result in lower rates of recidivism for participants with certain characteristics, who participate in treatment and who successfully complete the drug court program. These studies, however, are limited both in scope and consistency. For example, there are variations in how recidivism is defined as some studies do not distinguish between in-program and post-program

recidivism. And, time-frames during which recidivism is measured varies across studies. Further, the use of experimental or quasi-experimental designs is the exception rather than the rule. As a result, the findings reported by these studies are generally mixed and site specific. They have been unable to address questions of program impact. Although such problems may reflect constraints imposed on research projects and requirements of funding agencies, they do limit the generalizability of the findings and the ability to demonstrate whether drug courts are an effective tool to reduce recidivism.

As discussed in Chapter 2, the current study was not designed to assess whether drug court programs are more successful than traditional adjudication or other programs and hence, did not utilize comparison or control groups. The current study is concerned with the efficacy of the treatment delivery system as it pertains to drug courts. This study does, however, allow us to examine how some of the key components of drug court programs are related to post-program recidivism. It distinguishes between in-program versus post-program arrests and incorporates a fixed twelve month post-program follow-up to examine rearrest activity. Other studies have failed to make even these distinctions (Belenko, 2001).

This chapter, then, provides an opportunity to examine some rare data about rearrest activity among drug court participants at four drug court sites. By using bivariate and multivariate techniques, the goal of the chapter is to assess how variations in recidivism rates are related to differences among participant characteristics, various program compliance requirements such as drug use and treatment attendance, as well as program completion status.

Overall, findings in this chapter indicate that program completion status is one of the most important factors associated with post-program recidivism. For three drug courts in this study, program "success" (graduation) in drug court is related to "success" (no arrests) in the twelve month post-program follow-up. Interestingly, at the one site where completion status was not a significant predictor of recidivism, the low overall rate of recidivism found there was related to the high overall rate of treatment attendance.

The chapter is organized as follows. The next section discusses methods and the time-frame of the analysis. This is followed by a comparison of overall recidivism rates at each of the four sites. This includes a discussion of the timing to first arrest as well as the types of arrest offenses that occurred. By using bi-variate cross-tabular analyses, the third section examines factors associated with new criminal conduct. Multivariate logistic regression and structured equation models are introduced in the final sections of the chapter so as to identify to the most salient factors related to recidivism at each site.

Methods

As described in Chapter 2, arrest data was obtained from NCIC for 2357 participants discharged between January 1, 1997 and December 31, 2000. Data was collected for each participant who either graduated or was terminated and had at least twelve months time-at-risk beyond their date of program discharge. A fixed time-frame of

twelve months post-program follow-up is used to describe rates of post-program arrests[15]. For example, a participant discharged on January 1, 1998 was tracked for 12 months until December 31, 1998 to identify whether an arrest had occurred.

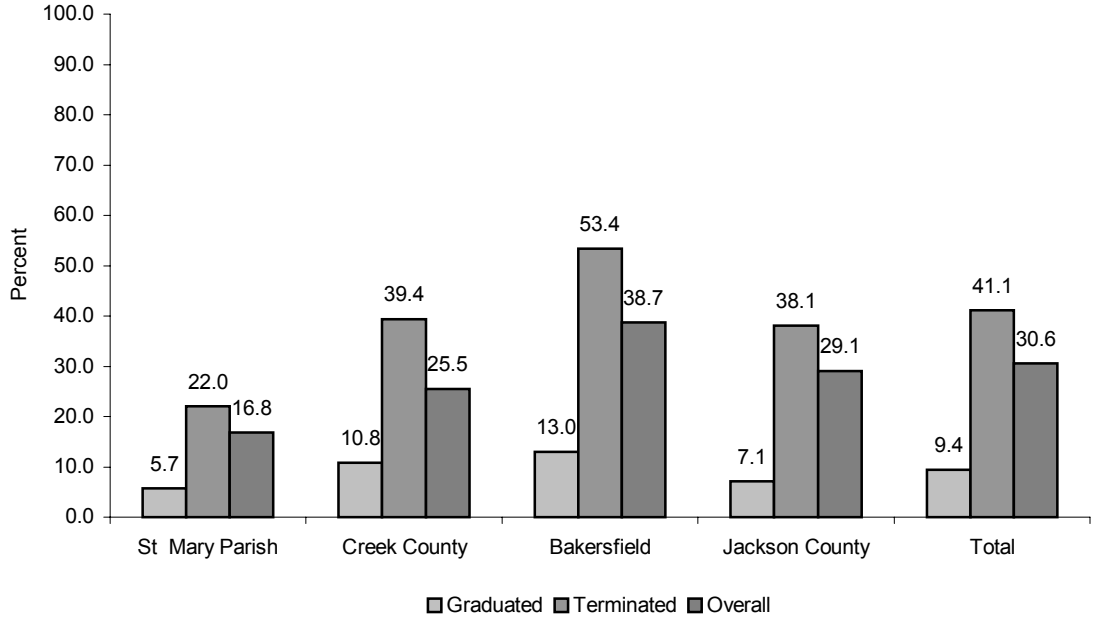
Stepwise logistic regression models are employed to test the impact of participant and program characteristics on post-program recidivism at each of the four sites. Post-program arrest serves as the dependent variable of interest. Those not arrested are coded "0" and participants who were arrested one or more times after program discharge are coded "1." The regression models predict the odds of arrest vs. no arrest at each site.

The last section of the report also provides structured equation models for each drug court program. Here, the research integrates all of the previous findings (factors associated with drug court graduation and post-program recidivism), in order to provide a more complete, holistic picture of significant relationships by simultaneously considering the explanatory effects of multiple variables.

Fixed 12–Month Follow-Up Post-Program First Arrests

Overall, findings indicate that 31% of the 2357 participants had one or more arrests during the twelve month post-program follow-up. Recidivism information is presented for each of the sites in the study in Figure 9.1 and Table 9.1. Findings indicate cross-site variations in the percent of participants rearrested. Recidivism rates range from a low of 17% at St. Mary Parish to a high of 39% at Bakersfield.

Figure 9.1 12-Month Fixed Follow-up Post-Program Arrests Outcomes



[15] The actual amount of time between participant discharge and the collection of recidivism data is of course variable and ranged between 12 months and 63 months.

These recidivism rates are consistent with those reported elsewhere and fall within the range of rearrest rates reported in those studies. For example, Belenko (2001) reports recidivism rates for four drug court programs range between 12% and 45% during a 24-month follow-up period. Post-program recidivism rates reported in this study, however, are lower than those reported by Latessa (2002). Latessa reports post-program recidivism rates of 41% for Ohio's felony drug courts and 32% for Ohio's misdemeanor drug courts. Recidivism rates for the programs in this study are also lower than reported for Baltimore City (see Chapter 1).

The most significant factor associated with variations in recidivism rates in this study is program completion status[16]. Simply stated, only 73 of the 779 graduates from these drug court programs were involved in a criminal offense leading to an arrest within one year after graduation. And, program graduates have substantially lower rearrest activity than terminated participants. Similar findings have been reported by Finnegan (1998), Peters (1999) and Goldkamp (2001). Referring to Figure 9.1, a greater percentage of terminated participants were rearrested during the post-program follow-up than graduates. Overall, 41% of terminated participants and 9% of graduates were rearrested. Differences by discharge status are statistically significant across all four sites.

In comparison with other sites, the St. Mary Parish drug court has the lowest rate of recidivism for both graduates (6%) and terminated participants (22%). Conversely, the Bakersfield drug court has the highest rate of recidivism for both program graduates (13%) and terminated participants (53%). Table 9.1 (below) reports recidivism rates by completion status. Of the 722 arrested participants, 90% of those arrested were terminated and 10% were program graduates. Arrested program graduates range from a low of 7% at the Jackson County drug court to a high of 20% at Creek County. These findings indicate that participants who were terminated are more than four times more likely to be rearrested than participants who complete the program through graduation.

Table 9.1 12-Month Fixed Follow-up Post-Program Arrests Outcomes

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	%	N	% G	%	N	% G	%	N	% G	%	N	% G	%	N	% G
No Arrests	83.2	183	36	74.5	143	58	61.3	443	51	70.9	866	38	69.4	1635	43
One or More Arrests	16.8	37	11	25.5	49	20	38.7	280	12	29.1	356	7	30.6	722	10
Total	100	220	32	100	192	48	100	723	36	100	1222	29	100	2357	33
% G T-Test Sig.			3.1***			4.8***			11.7***			11.4***			16.6***

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduated

[16] The finding that program completers are less likely than those expelled from the program to be arrested in the twelve month follow-up is an important substantive finding of some significance. Other possible findings in this regard – such as more graduates being arrested than those who were expelled – would seriously challenge the "success" of drug courts for *participants*. While the finding that program graduates have fewer arrests than unsuccessful completers is important, the interpretation of the meaning of this finding in terms of overall *program* success is debated in the literature. For example, Goldkamp (2001:32) argues that in the absence of an experimental design such findings merely indicate that the "successes succeed and the failures fail".

Length of Time to First Arrest

Several studies report findings that suggest the *length of time* to first post-program arrest is important in the assessment of recidivism as an outcome measure (Goldkamp et. al. 2001). Table 9.2 presents cross-site comparisons of the average length of time to first arrest within the twelve month fixed time-frame. Overall, findings indicate that the majority of participants were arrested within the first six months after program discharge. The median length of time to first arrest is 4 months with a mean of 4.8 months. The time of first arrest ranges from 1 day to 12 months after program discharge.

Length of time to first arrest varies by program completion status as the timing of arrests for graduates occurs later than it does for participants who were terminated from the program. Referring to Table 9.2, the median length of time to first arrest for terminated participants is 4.0 months in comparison to 6.5 months for graduates. This difference holds for three of the four drug courts in the study. The exception is the St. Mary Parish drug court where there are essentially no differences in the length of time to first arrest between terminated participants and graduates. The greatest difference in the median length of time to first arrest between graduates and terminates is at the Bakersfield drug court (5 months).

Table 9.2 Length of Time to First Post-Program Arrest By Discharge Status

Months	*St. Mary Parish*			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Median	4.0	4.0	4.0	8.5	4.0	5.0	8.0	3.0	3.0	6.0	4.0	4.0	6.0	3.0	4.0
Range	4-6	.13-11	.13-11	.07-12	.23-11	.07-12	.20-12	.03-12	.03-12	.43-12	.03-12	.03-12	.07-12	.03-12	.03-12
Mean	4.5	4.5	4.5	7.6	4.6	5.3	6.9	4.2	4.5	6.3	4.7	4.8	6.6	4.5	4.7
St. Dev.	1.0	3.14	2.98	3.97	3.04	3.43	3.56	3.66	3.74	3.42	3.49	3.5	3.49	3.51	3.57
N	4	33	37	10	39	49	34	246	280	25	331	356	73	649	722

$^{***}p<.001$, $^{**}p<.01$, $^{*}p<.05$; two-tailed tests
G=Graduated T=Terminated O=Overall

Overall, findings presented in this section of the chapter indicate that significantly fewer graduates were rearrested in the post-program follow-up and the timing of the arrests occurs later than it does for participants who were expelled from these programs.

In-Program and Post-Program Recidivism

In Chapter 8, we reported that participants who were arrested during drug court (in-program arrests) were less likely than those with no in-program arrests to graduate from the program. Belenko (2001) reports that few programs have examined the relationship between in-program and post-program recidivism. Are participants with in-program arrests more likely to recidivate? Cross-site comparisons about the relationship between in-program and post-program recidivism are presented in Table 9.3, controlling for program completion status. The cell values represent the percent of participants arrested.

Table 9.3 Relationship Between In-Program and Post-Program Recidivism

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
No In-Program Arrest	6.3	24.4	18.3	9.6	31.3	20.2	12.0	52.0	27.2	6.4	29.8	21.6	8.6	32.2	22.3
In Program Arrest	0	8.7	6.9	20.0	73.7	55.2	16.7	53.9	48.7	11.6	55.1	49.4	14.2	53.4	47.7
Chi-Square					11.6***	15.8***			35.2***		52.0***	89.9***		71.04***	158.2***

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduate T=Terminate O=Overall

There is a positive relationship between in-program and post-program recidivism. Participants with in-program arrests are twice as likely to be rearrested post discharge. A total of 48% of the 776 participants with in-program arrests also had an arrest in the twelve month follow-up. Among the 1581 participants who were not arrested during their participation in drug court, 22% were arrested after program discharge. This relationship holds for both terminated and graduated participants. A total of 53% of the terminated participants with in-program arrests were also rearrested in the post-program follow-up.

Treatment Attendance and Post-Program Recidivism

Several studies have examined the relationship between treatment attendance and post program recidivism. For example, Goldkamp et. al. (2001:53) found that the frequency of treatment sessions attended was inversely related to the recidivism rates for Las Vegas drug court participants. In this study, treatment attendance information was obtained for 1219 drug court participants. Table 9.4 examines the relationship between treatment attendance and recidivism, controlling for program completion status. It will be recalled from Chapter 8 that a treatment attendance standard of 70% of the minimum expected number of sessions was computed for each participant controlling for the length of time of drug court participation. The cell values represent the percent of participants arrested.

The findings in this study are consistent with those reported by Goldkamp (2001). Controlling for discharge status, Table 9.4 indicates that treatment attendance is inversely associated with post-program recidivism. That is, at three of the four sites terminated participants who attended less than 70% of the expected treatment sessions were more likely to be arrested than terminated participants completing more than the 70% standard.

Table 9.4 Relationship Between Treatment Attendance and Percent of Post-Program Arrests

	St. Mary Parish			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Less than 70% Tx	0	28.3	27.9	0	42.6	34.2	12.6	52.7	41.4	0	39.4	37.8	9.8	43.6	38.3
70% Tx or More	5.9	18.8	13.1	12.2	34.2	19.6	10.3	55.8	31.8	13.8	33.3	24.6	10.0	32.2	21.1
Chi-Square			6.7**			5.1*						4.1*		7.2**	37.8***

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduate T=Terminate O=Overall

Characteristics of Participants Associated With Post-Program Arrests

Cross-site comparisons of the relationship between demographic characteristics of participants and post-program recidivism are presented in Table 9.5. The cell values represent the percent of participants arrested. Overall, there are few statistically significant differences among the four sites in the relationship between participant characteristics and the occurrence of new criminal conduct. Significant differences are largely found in the Jackson County drug court across gender, race, age, marital status and employment characteristics[17]. Other findings are mixed and site specific. For example, the Creek County drug court is the only site where we find that high school graduates are less likely to be arrested than non-high school graduates. And for those participants at the Bakersfield and Creek County sites, participants with a prior treatment experience are less likely to be rearrested than participants engaging in treatment for the first time.

Table 9.5 Characteristics of Arrested Participants

	St. Mary Parish[b]			*Creek County*			*Bakersfield*			*Jackson County*			*Total*		
	G	T	O	G	T	O	G	T	O	G	T	O	G	T	O
Gender															
Male	5.6	21.3	16.5	12.7	39.7	26.8	10.5	56.9	41.0	9.0	40.9	32.4	9.5	41.8	31.9
Female	6.3	25.0	18.2	5.3	38.1	22.5	14.9	50.0	36.7	3.3	30.2	20.8	9.2	39.6	28.3
Chi-Square										3.8*	7.9**	16.1***			
Race															
Nonwhite	-	23.7	17.6	5.6	54.5	32.5	16.2	52.9	41.0	10.1	39.3	32.7	10.5	40.7	33.0
White	9.1	20.3	16.1	12.0	35.1	23.7	11.7	53.6	37.7	3.6	34.8	21.7	8.7	41.7	28.2
Chi-Square										5.7*		15.6***			6.2**
Age															
Under 30	6.5	22.8	18.2	12.5	40.4	29.1	17.0	56.3	41.7	8.6	46.1	36.2	11.1	45.5	35.2
30 and Older	5.1	21.1	15.5	9.8	38.5	23.0	10.7	51.8	37.1	5.6	27.9	20.8	8.1	36.9	26.6
Chi-Square											30.0***	35.1***		11.9***	20.2***
Education															
Less than HS	7.0	20.4	16.3	16.7	42.6	33.8	13.6	52.2	38.5	6.7	39.0	30.1	9.8	41.7	31.9
Hs Grad	3.7	25.0	17.7	8.7	36.5	20.7	10.2	59.7	39.7	8.6	33.1	24.1	8.4	38.7	26.0
Chi-Square						4.1*									6.7**
Employment															
Not Employed	4.8	20.8	16.2	6.7	29.3	19.7	12.5	50.9	40.7	6.8	42.4	34.6	9.7	44.2	34.0
Employed	7.1	25.0	18.1	12.7	46.6	28.9	13.8	53.4	33.5	5.0	27.9	18.8	10.2	38.2	25.7
Chi-Square											6.9**	14.3***			12.1***
Marital Status															
Not Married	6.7	21.6	17.1	11.4	42.9	27.9	12.9	52.8	37.9	6.0	38.7	29.7	10.2	42.3	31.2
Married	-	27.3	14.3	8.7	23.8	15.9	13.2	55.7	42.9	-	20.0	8.3	7.6	44.4	29.5
Chi-Square												7.5**			
Dependents															
No Dependent	10.3	21.9	18.5	10.5	39.0	25.3	11.7	53.1	38.8	8.0	39.9	30.6	9.8	43.1	32.5
Dependents	-	22.2	14.1	10.9	39.7	25.7	26.1	63.6	38.2	3.0	31.0	23.1	8.0	32.3	23.2
Chi-Square							3.8*				4.6*	5.2*		11.6***	15.3***
Prior Tx															
No Prior Tx	2.9	26.6	19.3	9.5	33.3	20.7	12.4	51.8	36.4	7.2	36.6	27.5	10.2	43.4	30.7
Prior Tx	8.6	16.9	14.2	15.8	51.5	38.5	17.2	59.0	49.6	5.6	38.1	29.3	10.9	41.5	32.9
Chi-Square						6.3**			7.8**						

***p<.001, **p<.01, *p<.05; two-tailed tests
G=Graduate T=Terminated O=Overall
[b] Chi-Square tests of significance not performed due to low cell counts.

[17] Differences at the Jackson County drug court should be considered carefully, however, given the large percentage of missing cases described in Chapter 2.

Post-Program Arrest Offenses

Few studies report specific arrest charges of drug court participants who are arrested. Overall, information about 47 different post-program arrests offenses representing the most serious arrest charge in the arrest event was collected from NCIC. Table 9.6 present cross-site information on 21 of the most frequently occurring arrest charges for the 649 terminated and 73 graduates who were arrested. The cell values represent the percent of participants arrested. Arrest offenses are arrayed by overall frequency of occurrence and appear in descending order by arrest type. The findings presented in Tables 9.6 and 9.7 indicate that participants with post-program arrests were charged with a variety of offenses ranging from drug related offenses to property offenses and assault.

The most frequent rearrests occur for drug related offenses with over sixty percent of the participants charged for drug related crimes. In this regard there were few differences between graduates (66%) and terminated participants (61%). Twenty percent of the participants who were arrested were charged with property crimes (receiving stolen property, burglary, burglary of a motor vehicle and theft). A higher percent of terminated participants (21%) than graduates (11%) were arrested for these offenses. There are few differences by program discharge status in the percent arrested for crimes against a person (robbery, felony assault, assault, and criminal threatening). A total of 8% of participants who were arrested were charged for these crimes.

Table 9.6 Comparisons of Post-Program Arrest Charges by Discharge Status for Those Arrested

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Total*		
	G	T	G	T	G	T	G	T	G	T	O
Possession of Scheduled Drugs	50.0	42.5	10.0	28.2	26.7	19.1	44.0	36.0	31.6	29.4	29.6
Under the Influence	-	-	-	-	17.6	32.6	-	-	8.2	12.3	11.9
DUI/DWI	-	-	20.0	5.1	8.8	7.3	12.0	2.4	11.0	4.3	5.0
Habitual DUI/DWI	-	-	20.0	10.3	2.9	4.9	-	1.8	4.1	3.4	3.5
Possession of Drug Paraphernalia	-	-	-	-	2.9	8.1	4.0	-	2.7	3.1	3.0
Distribution of Scheduled Drugs	-	3.0	-	5.1	2.9	-	4.0	7.9	2.7	4.5	4.3
Possession with Intent	-	-	-	12.8	8.8	1.2	-	0.3	4.1	1.4	1.7
Trafficking in Scheduled Drugs	-	-	-	-	-	0.8	4.0	4.2	1.4	2.5	2.4
Sub-total of Drug Arrests	50.0	45.5	50.0	61.5	70.6	73.9	68.0	52.6	65.8	60.9	61.4
Burglary of a Motor Vehicle	-	3.0	10.0	-	-	0.8	12.0	14.8	5.5	8.0	7.8
Theft	-	9.1	20.0	15.4	-	3.7	-	3.9	2.7	4.8	4.6
Burglary	-	6.1	-	2.6	-	2.0	-	6.9	-	4.8	4.3
Receiving Stolen Property	-	6.1	-	5.1	-	2.4	-	0.6	-	1.8	1.7
Passing Bad Checks	-	3.0	-	-	-	0.8	-	1.5	-	1.2	1.1
Forgery	-	3.0	-	-	2.9	0.4	4.0	0.9	2.7	0.8	1.0
Assault	-	9.1	10.0	5.1	5.9	0.8	4.0	1.8	5.5	2.0	2.4
Child Welfare Endangerment	-	3.0	10.0	-	5.9	3.3	-	1.2	4.1	2.0	2.2
Felony Assault	-	9.1	-	2.6	-	-	4.0	2.7	1.4	2.0	1.9
Robbery	-	-	-	-	-	0.4	-	3.3	-	1.8	1.7
Prostitution	-	-	-	-	-	2.4	-	0.3	-	1.1	1.0
Weapons Violations	-	-	-	-	-	-	4.0	2.1	1.4	1.1	1.1
Other♦	50.0	3.0	-	7.7	14.7	8.9	4.0	7.3	11.0	7.7	8.0
Total	100% (4)	100% (33)	100% (10)	100% (39)	100% (34)	100% (246)	100% (25)	100% (331)	100% (73)	100% (649)	100% (722)

Table 9.7 Categorized Post-Program Arrest Offenses by Discharge Status

	St. Mary Parish		*Creek County*		*Bakersfield*		*Jackson County*		*Total*		
	G	T	G	T	G	T	G	T	G	T	O
Crimes Against a Person	-	21.2	20.0	7.7	11.8	4.5	8.0	9.1	11.0	7.9	8.2
Property Offenses	-	30.3	30.0	23.1	2.9	10.2	16.0	28.7	11.0	21.4	20.4
Drug Offenses	50.0	45.5	50.0	61.5	70.6	74.0	68.0	52.6	65.8	60.9	61.4
Weapons Violation	-	-	-	-	-	-	4.0	2.1	1.4	1.1	1.1
Prostitution	-	-	-	-	-	2.4	-	0.3	-	1.1	1.0
Other♦	50.0	3.0	-	7.7	14.7	8.9	4.0	7.3	11.0	7.7	8.0
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	(4)	(33)	(10)	(39)	(34)	(246)	(25)	(331)	(73)	(649)	(722)

Table 9.6 also presents cross-site comparisons of offense charges. Other than charges for drug possession, charges for theft and habitual DUI/DWI represent the majority of arrests in Creek County. At Bakersfield, most participants were arrested on charges for "Under the Influence of Controlled Substances" representing 34% of terminated and 18% of graduates who were arrested. Other than drug related charges, Jackson County has more participants charged with motor vehicle burglary than any other site. Other than arrests for drug related offenses (50%), post-program arrest charges at St. Mary Parish are widely dispersed.

Logistic Regressions

Stepwise logistic regression models are employed to examine the relationship among participant characteristics, program compliance measures and completion status on post-program recidivism. The high degree of collinearity among many of the independent variables necessitates the use of the stepwise method. These multivariate models complement the preceding bivariate analyses by assessing the salience of each factor among control variables. Separate models are estimated for each site as variations in missing cases prohibit the inclusion of all variables at all four sites.

Table 9.8 presents the step-wise logistic regression results for the odds of post-program recidivism at each of the four sites. Beginning with the St. Mary Parish program, we find one variable significantly predicting the likelihood of post-program recidivism – treatment attendance. In the St. Mary Parish drug court, participants who attend a greater percentage of treatment sessions are statistically <u>less</u> likely to be arrested

♦ Other arrest offenses include: Operating After Suspension (6); Manufacturing Scheduled Drugs (6); Violation of Protection Order (5); Failure to Give Correct Information to an Officer (5); Criminal Threatening (3); Fraud (3); Disorderly Conduct (3); Unauthorized Use of Property (2); Vandalism (2); Escape (2); Contempt of Court (2); Obstructing an Officer (2); Forging Prescription Drugs (2); Gross Sexual Assault (2); Trafficking in Prison Contraband (2); Arson (1); Stalking (1); Hindering Prosecution (1); Criminal Restraint (1); Sexual Abuse of a Minor (1); Criminal Mischief (1); Driving without a License (1); Leaving Scene of an Accident (1); Vehicle Registration Violation (1); Furnishing Alcohol to Restricted Persons (1).

after program discharge. This is an important finding as it suggests that treatment attendance may have an overall net positive effect for both graduates and terminated participants. Given the absence of any other predictive variables, the model is weak with only 6% of the variance in recidivism explained.

Turning to the Creek County drug court, five variables were found to significantly contribute to the likelihood of post-program recidivism. Those who were arrested during drug court participation are 6.3 times more likely to be arrested after program discharge. And, discharge status is also significant. Those who graduated from the drug court are less likely to be rearrested. In comparison with the other three drug courts, the effect of discharge status is strongest in Creek County. The inverse of the odds ratio (.09) indicates that those who are terminated are nearly 11 times more likely to be rearrested in the twelve month follow-up than program graduates. The three remaining variables of significance pose some difficulty in interpretation. First, the data suggests that those that were employed at the time of their admission to the drug court are 3.1 times more likely to recidivate than those who were not employed. Second, those participants who had life-time use of alcohol are nearly 3 times less likely (inverse of .338) to recidivate than those participants with no life-time use of alcohol. Finally, those participants with percent positive drug tests (29% to 100%) are 4 times less likely to be rearrested than those with no positive drug tests. Unlike the model for St. Mary Parish, this model is more robust with 23% of the variance in post-program recidivism explained.

With respect to the Bakersfield drug court, only two variables contribute to the variance in recidivism. As with the Creek County drug court, discharge status is significant at the Bakersfield site. Those terminated are 7.2 times (inverse of .139) more likely to be arrested than program graduates. One history variable is significant. As the participant's age at first arrest increases, the likelihood of being arrested after program discharge decreases. Overall, 17.2% of the variance in recidivism is explained by this model.

Six variables are significant in predicting the odds of rearrest at the Jackson County drug court. In-program arrests are significant. Participants with an in-program arrest are 2.66 times more likely to have a subsequent arrest after program discharge. As in the case of both the Creek County and Bakersfield programs, discharge status is also significant. Graduates in Jackson County are less likely to be arrested than those that were terminated. Those terminated are 5.15 times (inverse of .194) more likely to be arrested than the program graduates. Unlike the other three sites, participants having positive drug tests are 2 times and 1.5 times less likely to be arrested than participants with no positive drug tests respectively. Female participants are 1.42 (inverse of .70) times less likely to be arrested than male participants. Finally, as in the case of the Bakersfield drug court, as the participant's age is inversely related to the likelihood of being arrested after program discharge. Overall, 17.3% of the variance in recidivism is explained by this model.

Table 9.8 Odds Ratios from the Stepwise Logistic Regression of 12 Month Post Program Recidivism on Participant Characteristics and Compliance Measures[a]

	St. Mary Parish	*Creek County*	*Bakersfield*	*Jackson County*
	OR	OR	OR	OR
Demographics				
Female (male = 0)	ns	ns	ns	.70*
Race (white = 0)	ns	ns	ns	ns
Age 20 – 29 (Less than 20 = 0)	ns	ns	ns	ns
Age 30 – 39 (Less than 20 = 0)	ns	ns	ns	ns
Age 40 + (Less than 20 = 0)	.[b]	ns	ns	ns
On or More Dependents (None = 0)	ns	ns	.[c]	.[c]
High School Graduate (Less than High School = 0)	ns	ns	.[c]	.[c]
Employed at Admission (Not Employed = 0)	ns	3.10**	ns	.[c]
Marital Status (Not Married = 0)	.[b]	ns	ns	.[c]
			ns	
History			ns	
Ever used Alcohol (No Use = 0)	ns	.338*	ns	.[c]
Ever used Marijuana (No Use = 0)	.[b]	.[b]	ns	.[c]
Ever used Crack/Cocaine (No Use = 0)	ns	ns	ns	.[c]
Ever used Methamphetamines (No Use = 0)	.[b]	ns	ns	.[c]
Ever used Opiates (No Use = 0)	ns	ns	ns	.[c]
Ever used Other Substances (No Use = 0)	ns	ns	ns	.[c]
Received Prior Treatment (No Prior Tx = 0)	ns	ns	ns	.[c]
One or Two Prior Arrests (No Arrest = 0)	ns	ns	ns	ns
Three or More Prior Arrests (No Arrest = 0)	ns	ns	ns	ns
Age at First Arrest (Log)	ns	ns	.320***	.356***
Age at First Use	ns	ns	.[c]	.[c]
Compliance				
Failure to Appear (No = 0)	.[b]	.[b]	ns	ns
Drug Court Arrest (No = 0)	.[b]	6.28***	ns	2.66***
Percent Positive UA .01 thru .08 (None = 0)	ns	.[b]	ns	.485***
Percent Positive UA .09 thru .28 (None = 0)	ns	ns	ns	.683**
Percent Positive UA .29 thru 1.0 (None = 0)	ns	.248***	ns	
Percent Tx Attendance (Actual/Expected Minimum)	.244***	ns	ns	.[c]
Status (Graduate =1)	ns	.091***	.139***	.194***
Constant	.726	1.08	40.67***	13.92***
Cox & Snell R^2	.058	.231	.172	.173
N	219	191	723	1221

***p<.001, **p<.01, *p<.05; two-tailed tests

[a] Unstandardized coefficients and standard errors available from author upon request. Only the main effect terms tested in the models are presented, the insignificant interaction terms are omitted to conserve space.

[b] Variables not tested in model due to low cell counts.

[c] Variables not tested due to high percentage of missing cases.

ns-Not Significant

As we can see, the results of the regression analyses indicate that program completion status is the most consistent factor associated with recidivism. In three of the four drug courts it was demonstrated that drug court "success" (graduation) leads to "success" (no arrests) in the twelve month post-program follow-up. However, it is interesting to note that the drug court where discharge status is not significant, St. Mary Parish, that greater exposure to treatment has a negative impact on the incidence of recidivism regardless of whether participants successfully completed the program or not.

Path Analysis

Throughout the course of analyzing participant level data, findings have been presented about three dependent variables. First, we examined the relationship between participant characteristics, program compliance measures and in-program recidivism. Second, we examined factors related to program completion (graduation). Finally, the recidivism analysis assessed the relationships between background factors, program compliance, and drug court completion status on post-program recidivism.

This analysis attempts to synthesize these findings in order to provide a more complete, holistic and explicit interpretation of the operant factors at each drug court that are associated with rates of post-program recidivism. This requires the use of a particular statistical method known as path analysis[18]. Path analysis is a "multivariate" approach that simultaneously considers the explanatory effects of multiple factors. Path analysis is unique in allowing not only independent (cause) and dependent (effect) variables, but also intervening or mediating variables. Intervening variables simultaneously measure the effects of some variables and the causes of others. In short, path analysis enables the construction of complex models that more accurately reflect social reality.

The findings from the logistic regressions in this chapter as well as in Chapter 8 informed the variable selection for the analysis that follows. Each path model includes only those variables that were statistically significant in previous analyses. Logical causal relationships were specified and the models were estimated. Given the exploratory nature of this project, modification indices offered by the statistical software were employed. Modification indices identify which relationships could be specified and which relationships could be eliminated in order to strengthen and improve the overall "fit" of the model. Each model presented is the single best-fitting model and all of the relationships included are statistically significant. It will be expected that these models will closely resemble earlier findings. However, this modeling is expected to produce new effects (and diminish some of the previous ones) as it incorporates all of the variables simultaneously.

Given the problem of multi-collinearity, many of the independent variables are specified to be correlated in the models. Therefore, these relations are controlled for by allowing particular independent variables to covary with one another. These covariances, usually represented by curved, double-headed arrows, are not presented in the diagrams

[18] See O.D. Duncan, 1960. "Path Analysis: Sociological Examples". American Journal of Sociology. Vol 72. #1. pp.1-19.

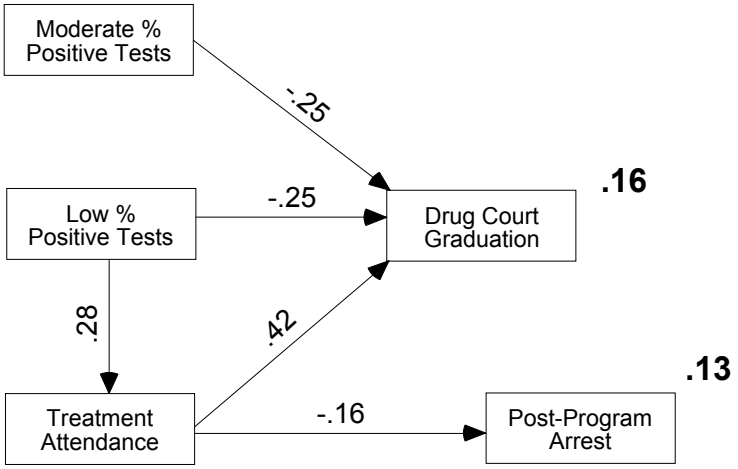
in order to conserve space and maximize clarity. A list of the model covariations are available from the authors upon request.

St. Mary's Parish

Figure 9.2 presents the best-fitting path model for the St. Mary Parish drug court. Overall summary statistics suggest that the model is a "good fit" (refer to the high goodness-of-fit statistic, low root mean square residual, low Chi-square statistic, and high probability value). Overall, the model reflects little departure from findings presented above. Participants with positive drug tests are less likely to graduate. And, attendance at a greater percentage of treatment sessions has a positive effect on graduation and a negative effect on post-program recidivism. One new relationship was formed, however, as participants with "low" percent positive tests are more likely to attend a higher percentage of treatment sessions[19]. Again, it is interesting to note that unlike the other drug courts in this study, drug court graduation is not associated with post-program recidivism at the St. Mary Parish program.

As expected, compared to the earlier regression analyses, there are some changes in the amount of the variance explained in the dependent variables in this model. More variance in recidivism is explained here (13% compared to 6%). Whereas, the variance explained in drug court graduation is diminished from a previous 24% to 16%.

Figure 9.2 St. Mary Parish Path Model



GFI = .992; RMSR = .006; Chi-square = 4.18; df = 4; prob. = .383; N = 219

Notes. Standardized path coefficients are located near the head of the arrows and the variance explained for each intervening and dependent variable is in bold, outside of the upper-right hand corner of the boxes. All paths are significant ($p<.05$; two-tailed tests).

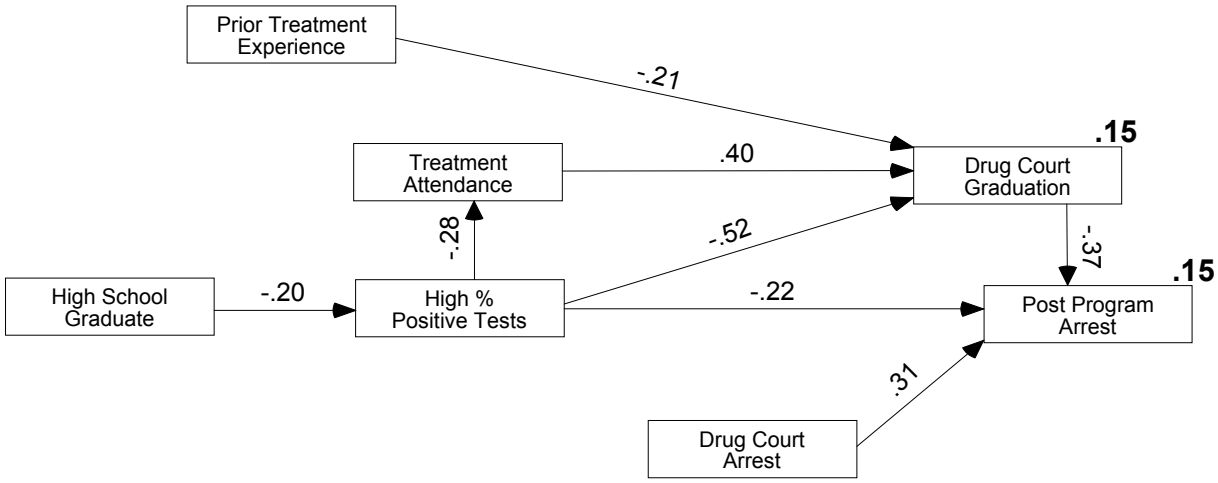
[19] It is important to note here that this is a relationship that could not be considered in previous regression analyses (that is, how compliance measures may effect one another). Naturally, many of these relations may also be reciprocal (or "dialectical") despite being identified as unidirectional in the diagram.

Creek County

Figure 9.3 presents the best-fitting path model for the Creek County drug court. As we found in St. Mary Parish, the summary statistics for this model can also be characterized as a "good fit". This model, however, reflects several departures from earlier regression analyses. Previous findings suggest a positive relationship between high school graduates and drug court graduation. In this model, the relationship is further specified with high school graduates being less likely to have positive drug tests. This model also specifies two new relationships in this regard with those having positive drug tests being less likely to graduate and less likely to attend a greater percentage of treatment sessions. Further, previous findings indicate a relationship between life-time use of amphetamines and in-program arrests and relationships between employment and life-time use of alcohol on post-program recidivism. These relationships are no longer significant in this model.

Similar to previous findings, participants with a prior substance abuse treatment experience are less likely to graduate and interestingly, those with "high" percent positive tests are less likely to be arrested in the post-program follow-up[20]. Other significant determinants of recidivism presented in this model include the positive effect of drug court graduation and the negative effect of in-program arrests. As expected, there are some changes in the amount of variance explained in the dependent variables in this path model (compared to the earlier regression analyses). Less variance in post-program recidivism is explained here (15% compared to 23%) as well as drug court graduation (25% to 15%).

Figure 9.3 Creek County Path Model



GFI = .978; RMSR = .011; Chi-square = 15.62; df = 12; prob. = .209; N = 191

Notes. Standardized path coefficients are located near the head of the arrows and the variance explained for each intervening and dependent variable is in bold, outside of the upper-right hand corner of the boxes. All paths are significant (p<.05; two-tailed tests).

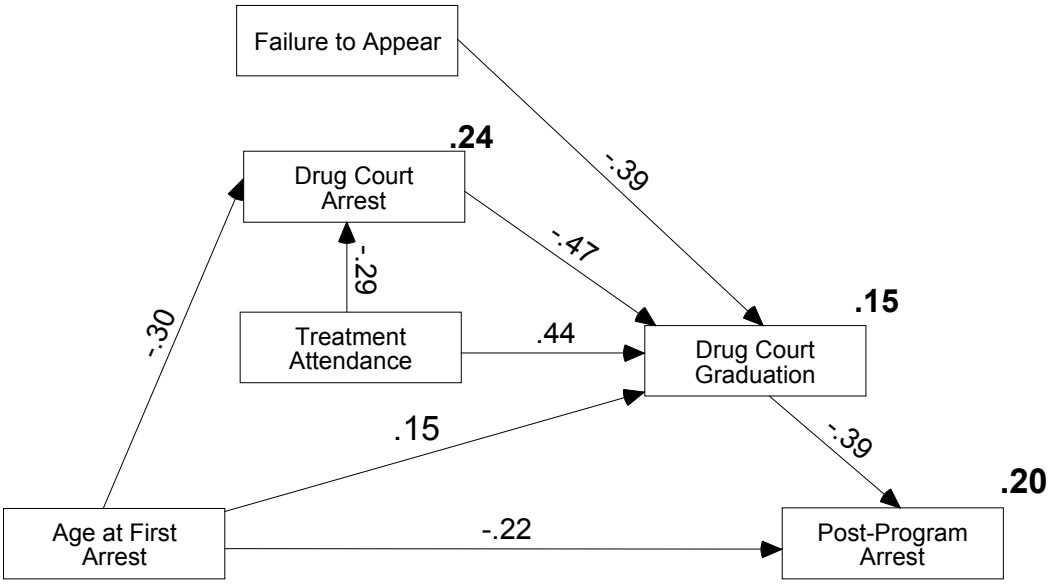
[20] Information pertaining to incarceration status at time of program discharge was not available and may account for this finding.

Bakersfield

Figure 9.4 presents the best-fitting path model for the Bakersfield drug court which can also be characterized as a "good fit". As in the case of the Creek County drug court, this model also reflects numerous departures from findings in earlier regression analyses. In this model, all but one participant characteristic remains significant among the two dependent variables pertaining to in-program and post-program recidivism. As age at first arrest increases, the likelihood of in-program and post-program recidivism decreases. And, age at first arrest also emerged producing a positive effect on the likelihood of graduation.

Similar to previous findings, treatment attendance is positively associated with graduation and negatively associated with in-program recidivism. And, participants arrested for FTA or other charges are also less likely to graduate. Lastly, as in the case of Creek County, drug court graduation decreases the likelihood of recidivism. More variance in post-program recidivism (20% versus 14%) and in-program recidivism (24% versus 12%) is explained in this model. Conversely, the amount of variance explained in drug court graduation is diminished from a previous 36% to 15%.

Figure 9.4 Bakersfield Path Model



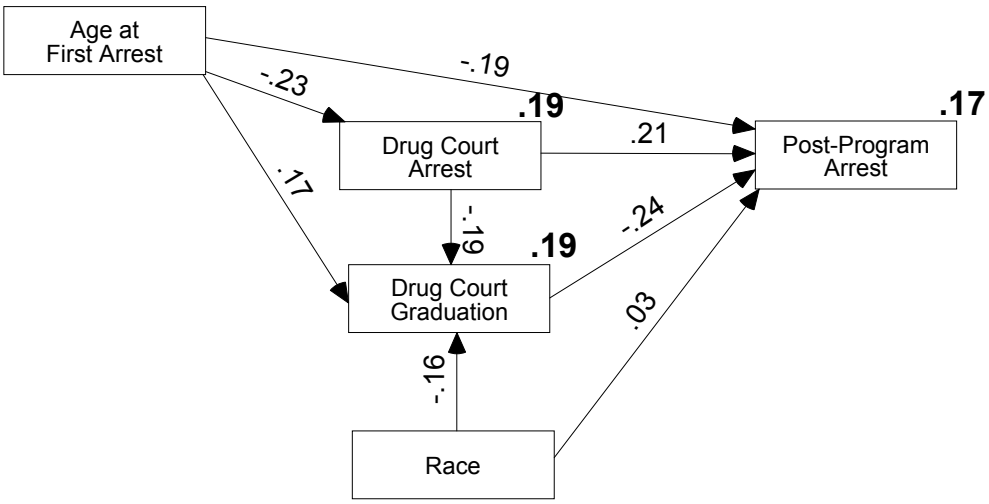
GFI = .998; RMSR = .001; Chi-square = 4.71; df = 6; prob. = .581; N = 723

Notes. Standardized path coefficients are located near the head of the arrows and the variance explained for each intervening and dependent variable is in bold, outside of the upper-right hand corner of the boxes. All paths are significant (p<.05; two-tailed tests).

Jackson County

Figure 9.5 presents the best-fitting path model for the Jackson County drug court. Much like the Bakersfield path model, age at first arrest remains significant among the two dependent variables pertaining to in-program and post-program recidivism. As age at first arrest increases, the likelihood of both in-program and post-program recidivism decreases. And, age at first arrest emerged producing a positive effect on the likelihood of graduation. One other participant characteristic, non-whites are more likely to recidivate in the post-program follow-up. And, as discussed in previous analysis, non-whites are also less likely to graduate. Contrary to previous findings, only one compliance measure remains significant in this analysis. Those arrested during program participation are less likely to graduate and more likely to recidivate in the post-program follow-up. Lastly, as in the case of Creek County and Bakersfield, drug court graduation decreases the likelihood of post-program recidivism. Less variance in post-program recidivism (17% versus 19%) and drug court graduation (19% versus 33%) is explained in this model. Conversely, the amount of variance explained in during-program recidivism is enhanced from a previous 3% to 19%.

Figure 9.5 Jackson County Path Model



GFI = 1.0; RMSR = 0.0; Chi-square = .026; df = 1; prob. = .871; N = 1221

Notes. Standardized path coefficients are located near the head of the arrows and the variance explained for each intervening and dependent variable is in bold, outside of the upper-right hand corner of the boxes. All paths are significant (p<.05; two-tailed tests).

One benefit of these path models is the ability to specify previously identified causal relationships in the presence of multiple dependent variables. At each site, one or more new relationships were identified and for three of the four sites, some previously identified relationships were diminished.

Similar to the findings presented in earlier regression analyses, overall results of the path analyses confirm, with the exception of the St. Mary Parish program, that program completion status remains the most common predictor of post-program recidivism. At each of the three other sites, drug court graduates are between 2 and 4 times less likely to recidivate than those terminated. The negative effect of treatment attendance on recidivism was identified at the St. Mary Parish program, whereas in two other sites (Bakersfield and Creek County) treatment attendance is only indirectly related to recidivism insofar as it is positively related to program completion.

Few participant characteristics remained significant in these analyses. No more than two participant characteristics at any one site were identified as having any causal relationship with any of the dependent or mediating variables. The most common, age at first arrest, was specified at both the Bakersfield and Jackson County drug courts. In both sites, as age at first arrest increases, the likelihood of in-program and post-program recidivism decreases and the likelihood of drug court graduation increases. At the two rural courts, new relationships between drug use and treatment attendance were identified. At the St. Mary Parish site, few positive drug tests are associated with increased treatment attendance whereas at the Creek County drug court, frequent positive drug tests is associated with decreased treatment attendance.

Since the findings pertaining to recidivism are mixed and site-dependent, it was not appropriate to construct an overall path model combining the four sites. At each drug court program, a specific set of variables – primarily those related to program operations as distinct from participant characteristics – were salient. Operant factors directly affecting recidivism include: program completion (at three sites), in program arrest and age at first arrest (at two sites) and treatment attendance, positive drug tests and race (at one site each).

Conclusions

The overall "success" of drug court programs is dependent on whether offenders abstain from new criminal conduct after program discharge. This study examined some important data on how compliance and non-compliance with program requirements of the drug court are related to post-program recidivism at four drug court sites. Overall, 31% of the participants had one or more arrests during the 12-month follow-up period. Post-program recidivism rates range from a low of 17% at St. Mary Parish to a high of 37% at the Bakersfield drug court. The recidivism rates reported here are consistent with those reported elsewhere and fall within the range of recidivism rates reported in those studies. This chapter examined how variations in recidivism are related to differences in program completion status, various program compliance requirements such as drug use and treatment attendance, as well as participant characteristics.

Overall, program completion status is the most important factor associated with recidivism. Offenders who "successfully" complete the drug court program through graduation were at least three times <u>less</u> likely to be arrested in the post-program follow-up. A total of 44 % of the terminated participants and 9% of graduates were rearrested.

Other factors associated with recidivism at one or more sites include: age at first arrest – as the participant's age at first arrest increases, the likelihood of being arrested after program discharge decreases; in-program arrest – participants with an in-program arrest are more likely to have a subsequent arrest after program discharge.

Although these findings are limited showing mixed results that are site dependent, they suggest the possibility of a net 'drug court effect' that may be affecting outcomes. That is, participants who comply with the performance expectations of drug court programs and attend treatment are less likely to recidivate than non-compliant participants. For example, at the St. Mary Parish drug court we found that completion status was not a significant predictor of recidivism, the low overall rate of recidivism found there was related to the high overall rate of treatment attendance regardless of whether participants graduated from the program or not.

Since the findings about recidivism are mixed and site dependent, there was no one overall "best fitting" model. At each drug court program, a specific set of variables - primarily related to program compliance requirements as distinct from participant characteristics - were operant. Operant factors affecting post-program recidivism at one or more sites revealed by the path analysis include: program completion, treatment attendance, in-program arrest, positive drug tests, race, age, and prior treatment experience.

Chapter 10

Conclusions

Overview

Drug treatment courts have been heralded as one of the major justice reforms of the 20th century (Goldkamp: 2001). The drug treatment court provides an intermediate sanction that combines the coercive power of the criminal justice system with substance abuse treatment. As such, they represent a nexus between criminal justice and substance abuse treatment systems that is intended *to reduce the recidivism of drug involved offenders by changing their drug using habits.* The drug treatment court model includes treatment, drug testing, supervision, and compliance management with the specialized feature of the presiding judge overseeing the progress of the addicted offender's rehabilitation.

In many ways, the concept of the 'drug treatment court' is intended to reshape criminal justice policy by creating a multidisciplinary team to address the criminal behavior and drug addiction of offenders through integrated programming. The theoretical assumption is that drug treatment is tied to reduced criminal conduct and the provision of treatment services is the means to achieve that goal. Stated simply, drug courts recognize that treatment is one of the primary interventions to achieve justice goals and the role of the court is to ensure these services are delivered.

Nationally, there is a great deal of diversity in how drug treatment courts have been implemented. There are also broad variations in the structure and operations of drug courts included in this study. Examining four well-established drug court programs, their respective treatment programs, and participant completion and rearrest activity, this study afforded an opportunity to examine some important data on drug court and treatment operations, program integrity, and the relationship between participation in these programs and recidivism. Here, we summarize those findings.

Chapter Summaries

Chapter 1 posed a dilemma. Despite a decade of research on drug treatment courts, we still lack critical information about the types and quality of treatment services delivered in the drug court model that may further our knowledge of factors affecting participant outcomes. To date, little is known about either the "black box" of treatment or the "black box" of drug court operations. The information we do have indicates variations in the development of key components of the drug court model – treatment, testing, and sanctions (Goldkamp, et. al. 2001). Moreover, there is a paucity of information about post-program outcomes in terms of drug use and recidivism. Despite a number of research limitations, the current study does provide important information about drug court operations, treatment delivery systems, and how participant compliance with drug treatment court requirements is related to program completion and recidivism.

Chapter 2 described a research design that combined an analysis of participant level data with information about current drug court and treatment operations at four drug court sites (St. Mary Parish, LA; Creek County, OK; Bakersfield, CA; and Jackson County, MO). Multiple sources of data include: interviews with court personnel and treatment administrators; surveys of treatment counselors; direct observations of treatment sessions; participant level data contained in individual treatment and drug court case files; and, NCIC data on in-program and post-program recidivism.

Findings from this study should be interpreted carefully as there are a number of limitations in the overall research design. The analysis of participant level data did not include a control group with which to compare outcomes. The analysis was also hampered by an overall lack of consistency in the types of data elements available at the four sites. Overall, not one program demonstrated an ability to successfully centralize in automated form the necessary information required to conduct a thorough assessment (e.g.: none of the programs maintained information surrounding sanctions and incentives). The study is further limited by the attempt to correlate current treatment practices with retrospective participant data. Information collected about treatment practices and participant data do not necessarily represent the same cohort of offenders.

Chapter 3 described each of the four drug treatment courts and provided a cross-site comparison of the structure and operations of those programs. Findings in Chapter 3 indicate that while there are basic elements common to each court, the four programs are diverse with respect to size, participant eligibility, program protocols, approaches, the number and content of drug court phases, and treatment and drug testing requirements.

Each of the four drug treatment courts offer a program lasting approximately twelve months. However, they target different populations ranging from first-time and second-time felony offenders at Jackson County and misdemeanant-only offenders at Bakersfield to both felony and misdemeanant offenders at the Creek County and St. Mary Parish sites. Three of the drug courts are post-plea whereas the Jackson County drug court is a pre-plea diversion court. All four programs offer a step-down phased system of requirements meaning that as participants progress through program phases, both treatment and court requirements decrease. Although step-down requirements vary by site, they are similar insofar as phases require attendance at treatment sessions, drug court status hearings, and participation in drug testing. Two sites have a four-phase program and two sites have a three-phase program. Treatment placement options also vary. Two of the programs offer a single track for all participants, two programs offer multiple treatment tracks.

In Chapter 4, we described the types of treatment programs associated with each of the four drug courts, the treatment services delivered, as well as the availability and use of ancillary services. Treatment services at three sites were delivered by a dedicated treatment provider contracted by the drug court. Treatment services at the Bakersfield drug court were provided by an array of local providers.

Overall, there was substantial diversity in the nature and types of treatment services provided and the content of those treatment services. Two of the direct treatment providers are fairly robust in the breadth of services they offer. In both the Jackson County and St. Mary Parish drug court programs such services include

residential treatment, intensive outpatient, outpatient services, relapse prevention and a therapeutic community. The direct service provider at the St. Mary Parish drug court offered more types of services than any of the other three drug court programs.

Each drug court in this study attempted to provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services which is one of the Key Components (4th) of drug courts. The research found several impediments to the delivery of this type of "continuum of care", including the reliance on informal referral systems for the provision of ancillary services (those beyond substance abuse treatment). In sum, treatment services at the four sites did not represent the standard of care with "highly individualized placements and lengths of stay in one or more modality contingent on individual need". At each site, when particular services were not directly provided, attempts were made to refer participants to other agencies for those services. However, there was no indication at any site that direct providers were substantively involved in ensuring that participants received services for which they were referred. This lack of follow-up generally reflects the lack of policy development and other impediments to coordinate service delivery. Treatment programs differ across sites, though there were some commonalities. Three programs employ from one third to two thirds of staff persons who were in recovery. There are variations in caseloads across sites, though three of the four sites had caseloads in the 25 to 35 client range.

In general, the form of the relationship that exists between the court and the substance abuse treatment agencies has an important impact on the nature and extent of service delivery (in terms of both substance abuse treatment and ancillary services). For example, at the Bakersfield drug court, the linkages between the court and the provider were largely informal. Treatment for the most part was "relied" upon, if convenient, instead of integrated into program protocols. This informality in some instances appears to translate into a lack of control over service delivery. Cancelled treatment sessions in the Bakersfield court program are the most notable example of this. On the other hand, the St. Mary Parish drug court developed a strong integrated model where the court and criminal justice players were knowledgeable about and relied upon treatment to address issues of continued drug use, noncompliance with supervision conditions, etc.

Results from surveys of counselors and treatment program administrators also suggest that some drug courts have difficulty providing ancillary services (especially for diverse client groups such as the visually impaired or Spanish speaking clients). In fact, only in Bakersfield were groups in Spanish available. Most programs offered a relatively standard set of outpatient and intensive outpatient services, with only limited capacity for residential services. Only about half the treatment programs reported providing any sort of aftercare treatment.

Most programs reported offering ancillary services (education, vocational education, housing, etc) through a referral system without having direct placement capabilities. However, the actual availability of these services was difficult to determine. These problem areas in service delivery likely provide substantial impediments to the provision of an appropriate continuum of care, as outlined in the Key Components of drug courts.

Additional attention is merited in terms of the delivery of an effective continuum of care, particularly for clients whose needs go beyond substance abuse. For example, additional educational and employment services, as well as ongoing aftercare are notably missing from these programs. Services for diverse populations are also missing (cultural and gender-specific issues were also infrequently addressed). Formalized cooperation between treatment providers and the courts is also lacking in some courts as is adequate oversight of treatment integrity by the courts.

The research was not designed to compare how the local treatment delivery system differs from treatment services delivered to drug court participants. It was found in Chapter 5 that staff employed by the treatment agencies for delivering services in the drug court context tended to have relatively low levels of education, but some had professional licensures or certifications and histories of overcoming substance abuse themselves. While many programs serve large proportions of minority clients, few minority counselors were employed. In terms of daily activities, most counselors reported conducting a single treatment group (about one hour long), as well as conducting one or two individual counseling sessions.

It was also found that a substantial proportion of treatment staff time was spent on admissions related duties. However, given the amount of time allocated to these duties, only a small percentage of time was dedicated to conducting clinical assessments. While all programs reported using a structured screening instrument and developing individual treatment plans, most sites reported little involvement of either the client or drug court staff in the treatment planning process.

There was also variability in terms of who was responsible for communicating expectations to clients. In some instances treatment staff members were responsible while in others court staff performed these tasks. Use of written contracts was also inconsistent, with some programs reporting reliance on verbal communication of program criteria. Some treatment programs reported using behavior modification techniques, with the most common sanctions pertaining to loss of privileges, extra treatment or support meetings, or increased drug testing. Typical rewards included verbal praise from counselors or other clients, while other programs reduced treatment or drug testing requirements as well. All programs reported drug testing and sharing that information with court staff.

Treatment staff were surveyed regarding their philosophy of treatment and responses were categorized into ten general models or theoretical perspectives. Counselors' philosophies of the causes of and what constitutes effective treatment for substance abuse suggest they take a broad, eclectic approach to treatment, endorsing only portions of each of the various philosophical approaches. This finding suggests lack of a coherent, consistent approach in the manner in which counselors not only think about but also how they respond to clients' drug abuse.

Overall results from Chapter 5 suggest several areas for improvement. First, qualifications and training of counselors could be improved. The second area requiring attention lies in developing a programmatic focus that centers on specific therapeutic approaches (e.g. specific cognitive behavioral strategies that have been consistently supported as effective in past research).

Findings in Chapter 6 focused on actual observations of treatment. The length of scheduled treatment sessions range from one hour and ten minutes to two hours with an average length of just under one and a half hours. However, the duration of actual treatment sessions was shorter. The amount of treatment time actually delivered (scheduled time minus breaks etc.) across all sites represents approximately 75% of the total expected treatment time.

Results from observations of treatment sessions themselves also indicate that drug treatment interventions being utilized can be characterized as an amalgamation of eclectic therapeutic approaches that result in delivering disparate treatment components in a superficial manner. In general, the observational results reveal a diverse pattern of approaches, including cognitive-behavioral techniques like trigger analysis and the examination of existing emotional processes coupled to a lesser extent with techniques derived from 12-steps programs (i.e., acceptance of powerlessness, reliance on a higher power). While the use of this broad-based approach to treatment may appear to be an effective intervention style, potentially addressing multiple client needs, these findings suggest that the actual result was a relatively small amount of time being spent on any specific treatment item or approach. In addition, some of these approaches are inherently inconsistent, in that they derive from distinct and conflicting theoretical assumptions about the underlying nature of addiction. These finding may indicate incoherent treatment modalities are being applied.

As previously discussed, programs addressing multiple client needs are in fact preferred in that they may be more effective in reducing substance abuse and criminal behavior, however this does not mean that treatment approaches based on incompatible philosophical positions should be incorporated together. In general these programs are more likely to deliver effective treatment if they coordinate a coherent treatment approach that can tackle multiple client needs in a consistent manner. The treatment literature suggests that cognitive-behavioral approaches are effective for offender populations. As such, this group of programs may benefit from solidifying their use of these types of techniques rather than attempting to utilize them in conjunction with so many other divergent approaches.

Related to the need to implement a coordinated strategy within those portions of the program that specifically target substance abuse issues is the need for programs to include additional services to address clients' multiple needs. In this case we are referring to ancillary services such as vocational education, parenting skills, and more consistent preparation for and use of aftercare treatment in the community. As a group these treatment programs were generally lacking in each of these areas, though the extent to which these services are adequately delivered through referrals to outside agencies is unknown.

Finally, none of the programs seemed to have an aftercare program that was widely attended by graduates. And, none of the programs appear to provide differentiated programming such as gender or culturally specific treatment, as evidenced in the low frequency with which these topics were observed in treatment groups. Again, the provision of specially tailored services might improve the efficacy of treatment for these specific sub-groups of clients. While white and male clients tend to dominate treatment groups in most sites, there were still substantial minority and female populations in each

jurisdiction who may benefit from services specifically tailored to their unique sets of needs. Culturally sensitive treatment would also be facilitated by the use of a more diverse group of counselors.

In general, the broad-based nature of the treatment provided seems to result in little time being spent on any particular approach to treatment, the delivery of sometimes incompatible approaches to treatment, and the inability to provide what might be more effective interventions (i.e., adequate attention to issues such as relapse prevention, educational needs, aftercare planning, and gender and cultural issues).

Whether these difficulties might be ameliorated by improvements in the integration of treatment and criminal justice services remains an open question, in general the overall quality of treatment appeared to be somewhat higher in those courts that were more directly affiliated with their treatment providers (i.e., the courts or local governments were more directly responsible for the operation of the treatment services employed by the court). Courts making use of existing treatment services in the community appear to have several issues regarding accountability and therapeutic integrity to overcome if they are to deliver high quality treatment services to their participants. We return to this issue in the discussion of treatment and court integration relative to the results of Chapter 7.

Chapter 7 provided a discussion of integration of court and treatment operations. At the heart of the drug court is an attempt to achieve a new working relationship between treatment providers and the courts (Goldkamp, 1999: 170). This requires a level of integration between treatment and the courts that has not previously existed. Bringing treatment and criminal justice together in an attempt to create this "seamless system" highlights differences and conflicts in values, goals, and methods between the courts and treatment profession (See Taxman, 2000 and Goldkamp,1999: 170).

Results from surveys of treatment staff reveal that in general they believe communication with the drug court was slightly better than average in terms of effectiveness and that this communication was generally bilateral. Most felt that there were formalized lines of communication between the two parties in terms of drug testing information. Treatment staff commonly reported that drug court personnel attended treatment planning meetings, but also reported that court staff were less frequently involved in the actual treatment planning process. Court staff generally reported only a passing familiarity with the goals and techniques of substance abuse treatment, but in some instances did not appear to have specific knowledge of the process, variations and limitations of substance abuse treatment. Few court staff report having attended any treatment sessions. Additional cross-training for staff may improve this level of familiarity and further improve levels of communication and cross-program integration.

Integration issues between treatment and court operations in the drug court context seem to be addressed through several common mechanisms: 1) Program integration occurs by combining court and treatment requirements for participants in the phase system; 2) Institutionalized lines of communication between court and treatment operations occur through weekly pre-court meetings where court and treatment staff meet and discuss client progress; 3) Drug courts in this study also integrate staff by placing

representatives from both treatment and court staff on drug court steering committees and other decision making and policy making bodies.

Integration is not, however, simply a matter of cooperation and cross-program familiarity by staff, it involves different levels of system integration– philosophical, policy, and operations. Moreover, the types of integration that are best for drug courts have yet to be demonstrated. By design, various components of criminal justice and substance abuse treatment systems are intended to work together as part of the drug court model to combine the coercive power of the court with what is hopefully effective and scientifically based treatment practices (Belenko, 1998:6). We know very little about the impediments to forming this level of integration. Future research might consider addressing these issues: formal linkages in terms of treatment delivery (especially to ensure delivery of ancillary services that clients are referred); oversight mechanisms to reduce the number of cancelled meetings; and continued development of policy-level integration so that joint decision making roles are spelled out in terms of clinical and legal assessments, program advancement, and program discharge.

Results from participant data analyzed in Chapters 8 and 9 addressed how compliance with program requirements of drug treatment courts were related to program compliance and post-program recidivism. The sampling frame consists of 2357 participants who were enrolled one or more days between January 1st 1997 and December 31st 2000, that were either terminated or graduated, for whom both a minimum amount of follow-up time (12 months) had elapsed since discharge, and for whom NCIC criminal history information was available.

Information about offender behavior and program participation was collected both during their program participation (i.e., drug testing, treatment, and graduation) and rearrest data was gathered for the 12-month post-program period. The data set that was compiled across the four sites includes program information (e.g., drug court program start and end dates, number of treatment sessions attended, number of drug tests administered and number of positive tests), characteristics of participants (e.g., age, gender, ethnicity, marital status, substance abuse histories, drugs of choice, etc.), type of graduation (i.e., graduates/terminates, exceeded program timeframe), and rearrests during and after program participation. For the most part, more complete information was maintained by the treatment providers (as compared to the courts) and therefore the analysis of participant data tends to over-represent those drug court participants who actually attend their mandated drug treatment services. Rearrest data was gathered from the National Crime Information Center (NCIC) for each site.

Rates of program completion reported in this study are somewhat lower than reported nationwide. A total of 779 (33%) of the 2357 participants graduated from these programs and 1578 (67%) were terminated. Program completion rates range from a low of 29% to a high of 48%.

Overall, there were race and ethnic differences in program completion with race and minority groups being less likely than white non-Hispanics to graduate from drug court. Since this is a retrospective study, it is not known how these findings articulate with the lack of diversity found among treatment staff and lack of culturally specific programming discussed in Chapter 5. However, such a connection is being made

between gaps in treatment programming and "unsuccessful" program outcomes among minority participants. Such findings bear further research.

Participant level data analyzed in Chapters 8 and 9 are concerned with three issues: 1) Examining the integrity of drug court by comparing program protocols against actual operations; 2) Examining participant compliance with drug court requirements; 3) Identifying how various participant characteristics and functional components of the drug court program are associated with program completion; 4) Identifying how these factors are associated with post-program recidivism.

Ideally, the drug court model provides an integrated program to address the chronic nature of addiction through drug testing, sanctions, frequent status hearings and substance abuse treatment. This study assessed a number of issues about the "black box" of the drug court model by assessing the integrity of several core components of drug court programs. The protocols of important components of the drug court model were compared with actual drug court operations. In an analysis of length of program participation, drug testing, and treatment attendance, the findings in this study indicate that there are gaps between drug court program protocols and actual drug court operations.

Findings in the four areas of program participation, treatment attendance, drug testing, and in-program recidivism are worth noting in this regard. Although the overall mean length of attendance in drug court was within 98% of the scheduled length of the program, the amount of time some clients participated in drug court exceeded the program's intended length suggesting that the twelve month time frame is generally too short for some offenders. For example, more than 24% of participants were discharged from the program (or about 18% of the expelled participants and 38% of graduates) after attending the program for more than 125% its scheduled length. While one advantage of the drug court program is to allow some flexibility for offenders who are making progress by extending their participation, it is unclear about the criteria being used to make these individual cases decisions and override program requirements. Since 18% of those who completed more than 125% of the program were subsequently expelled from the program, there may be a further problem of net-widening effects. Given that 53% of the graduates participated in the program past the expected program length, this suggests that the 12 month time frame may be too short to address the relapsing nature of addiction.

There were also gaps between program treatment attendance requirements and actual attendance at treatment sessions. Overall, 64% of the participants did not attend a minimum number (70%) of the required treatment sessions. These findings also indicate that more than a third of the participants (36.5%) graduate from drug court programs without having completed the minimum number of treatment sessions called for by program protocols. Conversely, a number of participants (10%) who were expelled from drug court actually attended more than 100% of the treatment sessions required by the program's treatment protocol.

In addition, the study found gaps between drug testing requirements and actual drug testing practices. More than half of the participants (54%) did not receive a minimum (70%) number of drug tests called for by the program's drug testing

requirements. A total of 33% of the graduates and 64% of terminated participants failed to receive 70% of the scheduled drug tests.

As expected, the majority of drug court participants were not in compliance with one or more program requirements. More importantly, failure to comply with these requirements is related to unsuccessful completion of the program: A total of 59% of the expelled clients participated in less than half of the drug court program; 76% did not attend the minimum number of treatment sessions; and, 64% of the expelled participants did not receive the minimum number of drug tests.

Since the major goals of drug court programs are to reduce substance abuse and criminal offending behaviors, drug court programs require that participants comply with certain performance expectations including not engaging in new criminal conduct and abstinence from the use of alcohol and drugs. This study examined how in-program recidivism and positive drug tests were related to program completion. Overall, the findings in this study indicate that 17% of the participants were arrested once and 16% were arrested two or more times (in-program arrests) during their participation in drug court. In addition, 76% of participants tested positive for drug use one or more times and 61% tested positive two or more times during program participation.

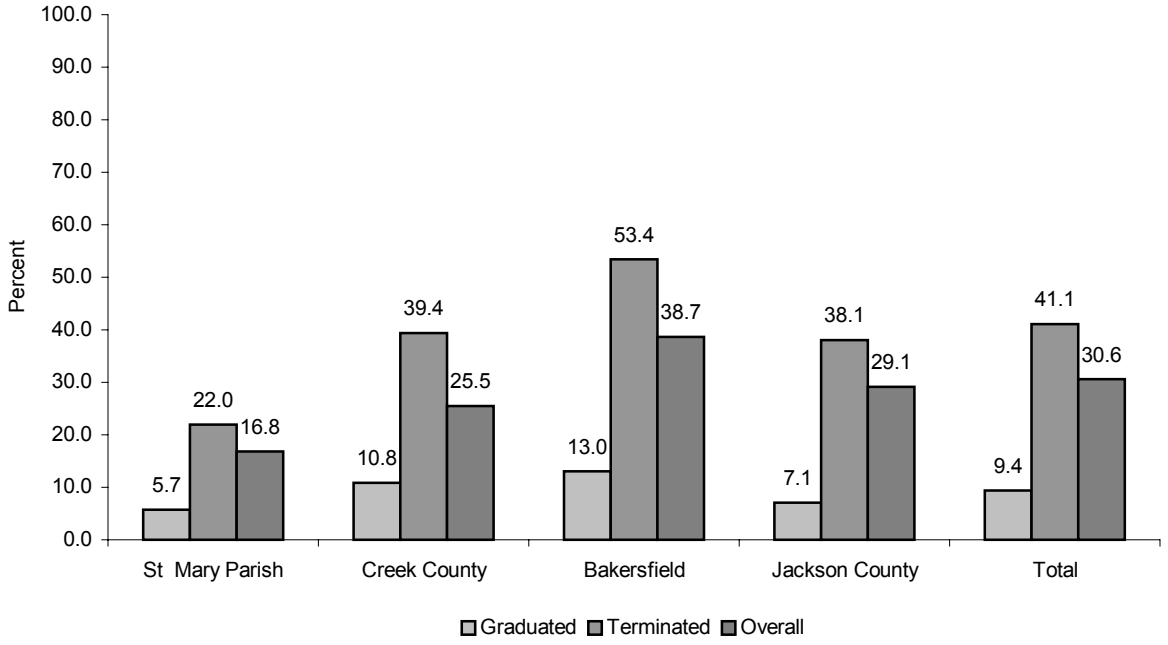
As expected, positive drug tests and in-program arrests are both negatively associated with program completion. A total of 85% of those with in-program arrests and 50% of the participants with one or more positive drug tests were terminated from the program. Put differently, participants terminated from the program are two to three times more likely to test positive for drug use and four to five times more likely to be arrested during drug court program participation than those who graduated.

The overall "success" of drug court programs is dependent on whether defendants commit more crimes after program completion. Rearrest data was obtained for all of the 2357 offenders for 12 months past the date of discharge from the drug court program. As a result, this study was able to examine some rare data on the relationship between compliance with program requirements on post-program recidivism.

As shown in Figure 10.1, findings indicate that 31% of the 2357 participants had one or more post-program arrests during the twelve month follow-up. Rearrest rates range from a low of 17% to a high of 37%. Chapter 9 examined how variations in recidivism is related to differences among participant demographic characteristics, various program compliance requirements such as drug use and treatment attendance, and program completion status.

The most significant factor associated with recidivism is program completion status. Simply stated, only 73 of the 779 graduates from the drug court programs were involved in a criminal offense leading to an arrest within one year after graduation. And, program graduates have substantially lower rearrests than those expelled. Overall, 41% of the terminated participants and 9% of the graduates were arrested. This means that of the 722 arrested participants in the post-program follow-up, a total of 90 % were expelled. Similar findings have been reported by Finnegan (1998), Peters (1999) and Goldkamp et. al.(2001).

Figure 10.1 12-Month Fixed Follow-up Post-Program Arrests Outcomes



As shown in Figure 10.1, the rate of post-program recidivism is consistently higher for terminated participants than graduates across all four sites. Moreover, terminated participants were arrested in a shorter period of time. Terminated participants who were arrested took an average of 4.5 months until they were arrested whereas those graduates who were arrested took about 6.6 months.

Like other studies, the findings in this study indicate that program completion status is the most consistent variable associated with post-program recidivism. In other words, offenders who "successfully" complete the drug court program through graduation are three times less likely to be arrested in the post-program follow-up than terminated participants. And, drug court graduates who were arrested took a longer period of time before they were arrested. In sum, if these drug court programs are reducing recidivism, it would appear they are having their greatest effect on those individuals who successfully completed the program.

Other factors associated with post-program recidivism at one or more sites include: treatment attendance - with participants with low attendance at treatment sessions having a greater likelihood of being arrested after program discharge; race/ethnicity - with race and ethnic minorities being more likely than white non-Hispanics to be arrested; age at first arrest – with participants having prior arrests at younger ages being more likely to be rearrested; gender - with males being more likely to have a post-program arrest; and, participants with arrests during their participation in drug court. Overall, participants with in-program arrests were twice as likely to have a subsequent post-program arrest. Among the 1581 participants with no in-program arrests 23% were arrested after program discharge. And, a total of 48% of the 776 participants with in-program arrests were also arrested in the twelve month follow-up.

The results of a series of logistic regression models confirm that program "successes" in terms of graduation are also "successful" post-program in terms of recidivism whereas program "failures" (participants terminated from the program) do not do as well after program discharge. The results of a series of path analyses support this finding. They indicate that participant compliance with key components of the drug court model operate through program completion thereby affecting post-program recidivism. However, as reiterated throughout, these findings are limited as they show mixed results and are site specific.

Nevertheless, the fact that program graduates are less likely to be arrested is a substantive finding of some significance. Overall, the findings in this research confirm what has been found in other studies – namely that drug court graduates "succeed" and terminated participants "fail" – have policy implications. Nationally, it suggests that improvements in program retention and program completion should remain focal points of drug court programs (See also Bavon, 2001). Such a recommendation is justified given the relatively high rate of unsuccessful terminations reported in this study and throughout the literature.

At the onset of this discussion, we described the promise of the drug court - that drug courts have the potential to become an effective modality to reduce substance abuse and recidivism by providing offenders drug treatment services, providing the leverage necessary to insure their participation in drug treatment and achieve abstinence, providing swift and certain negative sanctions for negative behavior, and providing the addict-offender with time to adjust to treatment, testing and sanctions. Is it possible for drug treatment courts to achieve these goals?

The findings of this and other major studies of drug court programs have not identified theoretical flaws in the 'drug court' model. Continued enthusiasm for drug treatment courts is warranted. However, it is possible that the drug court model may falter in implementation. In fact, an examination of program integrity and actual drug court operations indicates a number of ways that drug court programs may actually be failing their clients. Addressing such issues in the future will improve program outcomes.

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